PATIENT FOLLOW UP INFORMATION: **Today's Date:** _____

Name:_____ Birthdate: _____ Age:____ Height:_____ Weight:_____

Address: (if changed from last visit) _____

Contact Phone Number: (if changed from last visit) _____

***Has your Insurance changed since your last visit?** ☐NO ☐YES, Please give new card to the front desk

Are your currently working: Yes No If yes, current employer: _____

Why are you here today? _____

For each, circle what BEST applies:

The pain is: BETTER SAME WORSE

The pain is: DULL SHARP ACHY THROBBING BURNING OTHER_____

On a 0-10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

What makes it worse? _____ Better? _____

Information below is to update NEW Changes to Medical History since last visit!

- If no new changes please check here and sign form ( ) **NO NEW CHANGES**

NEW Medical, Surgical, Family, Social or Smoking History: ( ) NONE

Explain: _____

NEW SYMPTOMS: ( ) NONE Check all that apply:

( ) Yes	( ) No	General Health:	weight loss, weight gain, fever, night sweats, fatigue
( ) Yes	( ) No	ENT:	headaches, difficulty swallowing, nose bleeds
( ) Yes	( ) No	Cardiovascular:	chest pain, palpitations, fainting
( ) Yes	( ) No	Respiratory:	shortness of breath, wheezing, coughing, snoring
( ) Yes	( ) No	Gastrointestinal:	heartburn, nausea, constipation, diarrhea
( ) Yes	( ) No	Urinary:	urinary frequency, urgency, pain, incontinence
( ) Yes	( ) No	Musculoskeletal:	joint pains, swelling, stiffness, muscle pain
( ) Yes	( ) No	Skin:	skin changes, poor healing, rash, itching
( ) Yes	( ) No	Neurological:	numbness/tingling, unsteady gait, dizziness, tremors
( ) Yes	( ) No	Hematologic:	easy bleeding, bruising
( ) Yes	( ) No	Other:	_____

ANY NEW ALLERGIES to medication: ( ) NONE List_____

Patient or responsible party signature_____ Date_____

Physician review_____ Date_____