PATIENT HEALTH HISTORY → *Update*

Today's Date _____

Name: _____ ❒ Male ❒ Female

DOB: _____ Height: _____ Weight: _____

Reason for today's visit:_____ ❒ **Left** ❒ **Right**

Is this the result of a: ❒ Injury ❒ Car Accident ❒ Workplace injury ❒ Not an injury

If you have pain, describe your pain: ❒ achy ❒ sharp ❒ burning

Any related symptoms? ❒ pain ❒ swelling ❒ bruising ❒ numbness

Current pain level (1-10, 10 being the worst): _____ Pain at its worst: _____ Pain at rest: _____ Pain with activity: _____

Do you use tobacco? ❒ Yes ❒ No

Do you not feel safe at home? ❒ Yes

REVIEW OF SYSTEMS **Check all that Apply**

If yes to any of the following, is your primary care physician/provider aware of your symptoms? ❒ Yes ❒ No

(Please note that if your primary care physician/provider is not aware of any of these symptoms that you should notify him/her.)

Abdominal pain	❒	Dizziness	❒	Nausea	❒
Anxiety	❒	Excessive bruising	❒	Night sweats	❒
Arm numbness/tingling	❒	Excessive thirst	❒	Rash	❒
Balance issues	❒	Fevers, chills	❒	Shortness of breath	❒
Chest pain	❒	Headaches	❒	Urinary changes	❒
Cough	❒	Heartburn/reflux	❒	Vomiting	❒
Depression	❒	Leg numbness/tingling	❒	Weight loss	❒

MEDICATION LIST **(include prescriptions, herbals, and over-the-counter medications)**

❒ **No changes since last visit**

Medication ~ update since last visit:	**Strength (dosage):**	**Times per day:**

ALLERGIES ❒ **Yes (see below)** ❒ **No Known Drug Allergies** ❒ **No update since last visit**

Medication You Are Allergic To:	**Reaction:**

Date/Time: _____ Patient/Guardian Signature: _____

Patient Label