Re-Examination: History

Name:____ Date: __________________

Chief Complaint: ____

When during the day do you have your pain? ____

Is your pain constant? (Circle One) Yes No **If not, how often do you have pain?**__________ **How frequent is the pain?**________

What makes your pain worse? ____

What makes your pain better? ____

Describe your pain (circle all that apply)

A. Neck: (Sharp)(Burning)(Shooting)(Achy)(Knife-like)(Twisting)(Pressure)(Lancinating)(Tooth-Ache)(Deep)(Heavy)(Gnawing)
B. Do you have any weakness or pain shooting down your arm? (circle one) Yes No
   a. If yes, describe ____
C. Mid-Back: (Sharp)(Burning)(Shooting)(Achy)(Knife-like)(Twisting)(Pressure)(Lancinating)(Tooth-Ache)(Deep)(Heavy)(Gnawing)
D. Low Back: (Sharp)(Burning)(Shooting)(Achy)(Knife-like)(Twisting)(Pressure)(Lancinating)(Tooth-Ache)(Deep)(Heavy)(Gnawing)
E. Do you have any weakness or pain shooting down your leg? (circle one) Yes No
   a. If yes, describe ____
F. Other: (i.e. shoulder, knee, elbow, wrist)____

NEW HISTORY

Are you taking any NEW medication since last exam? ____

Any NEW medication allergies or other allergies since last exam? ____

Any NEW illnesses, injuries, surgeries, or hospitalizations since last exam? _______________________________________

Is there a chance you are pregnant? Circle One: Yes No

Any changes in your FAMILY HISTORY since your last visit (parents, siblings, children, grandparents)?

____

Any changes in your SOCIAL HISTORY since our last visit (marital status, employment, drugs, alcohol, tobacco, education)?

____

Any additional treatment no provided in this office since your last exam?____

Circle any **NEW** symptoms since last exam:

Constitutional: chills – fatigue – weight loss or gain – daytime sleepiness
Eyes: eye pain/pressure – vision changes
Ears, Nose, Throat: ringing in ears – hearing loss – dizziness – sinus pain – sore throat – snoring
Cardiovascular: chest pain – palpitations – ankle swelling – wake short of breath
Respiratory: cough – wheezing – shortness of breath – coughing up blood
Gastrointestinal: trouble swallowing – abdominal pain – bowel irregularity – heartburn
- nausea/vomiting – rectal bleeding
Genitourinary: painful urination – blood in urine – frequent urination – prostate problems
– loss of bladder control
Musculoskeletal: joint aches – muscle aches
Skin: rash – itching – hives – skin or hair changes
Neurological: passing out – headache – weakness – numbness/tingling – memory loss – seizures
Psychological: depression – anxiety/panic – nervousness – mood changes – tension
Endocrine: feeling warmer than others – feeling cooler than others
Hematology/Lymphatics: easy bruising – bleeding problems – sweating at night – swollen glands
Allergies: environmental allergy sneezing fits

REVIEW OF SYSTEMS

I have reviewed with the patient and everything not circled is unchanged from unless noted in last visit, history.

Doctor Initials: ____________

Doctor Initials: ____________

Re-Examination: History

Do you feel your treatment has helped? (circle one) YES N

Your level of Pain – *Please circle a number*

Your pain right now

No pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to hospital
0	1-2-3	4-5-6	7-8	9-10

Your average pain

No pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to hospital
0	1-2-3	4-5-6	7-8	9-10

Your worst pain

No pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to hospital
0	1-2-3	4-5-6	7-8	9-10

FUNCTION: Since your last visit how much has your pain interfered with your life:

1. Ability to Work:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
2. Ability to Sleep:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
3. Ability to participate in social activities:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
4. Ability to do household chores:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
5. Relationship with family:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
6. Sexual Activities:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
7. General mood:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
8. Do you need to lie down during the day due to pain? (circle one) YES NO
9. If so, lease circle how many times on average you need to lie down during the day? 1 2 3 4
10. Do you wake up during the night because of pain? (circle one) YES NO
11. Do you feel rested in the morning? YES NO
12. Please circle the average number of hours you sleep at night?
    0 1 2 3 4 5 6 7 8 9 10

Doctor's Notes:
____
____
____

Reviewed by Doctor ____________________