MN SPINE AND SPORT
MOVE BETTER. FEEL BETTER. LIVE BETTER.

Re-examination: History

Name: _____Date: _____

Chief Complaint: _____

Do you feel your treatment has helped? YES NO

Is your pain constant? (Circle One) Yes No

What makes your pain worse? _____

What makes your pain better? _____

When during the day do you have your pain? _____

Describe your pain (circle all that apply)

Neck: Sharp-Burning-Shooting-Achy-Stabbing-Twisting-Pressure-ToothAche-Deep-Gnawing-Stiff-Sore

Do you have any weakness or pain shooting down your arm? Yes No

Do you have headaches? Yes No Please describe _____

Mid-Back: Sharp-Burning-Shooting-Achy-Stabbing-Twisting-Pressure-ToothAche-Deep-Gnawing-Stiff-Sore

Low Back: Sharp-Burning-Shooting-Achy-Stabbing-Twisting-Pressure-ToothAche-Deep-Gnawing-Stiff-Sore

Do you have any weakness or pains shooting down your leg? Yes No

Other: (i.e. shoulder, knee, elbow, wrist) Please describe _____

When during the day do you have your pain? _____

NEW HISTORY

Are you taking any NEW medications since last visit?_____

Any NEW medication allergies or other allergies since last visit: _____
Any NEW illnesses, injuries, surgeries, or hospitalizations since last visit: _____
Is there a chance you are pregnant? 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)?

_____

REVIEW OF SYSTEMS Circle any NEW symptoms since last visit:

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: sneezing fits

Doctor Initials: _____

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Re-examination: History

<u>Your level of Pain</u> – *Please circle a number*

<u>Your pain right now</u>
0 1 2 3 4 5 6 7 8 9 10
<u>Your average pain</u>
0 1 2 3 4 5 6 7 8 9 10
<u>Your worst pain</u>
0 1 2 3 4 5 6 7 8 9 10

<u>FUNCTION</u>: Since your last exam how much has your pain interfered with your life
Please circle a number

Ability to Work:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Ability to Sleep:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Ability to participate in social activities:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Ability to do household chores:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Relationship with family:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Sexual Activities:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
General mood:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes
Ability to Exercise:
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Do you need to lie down during the day due to pain? YES NO
If so, please circle how many times on average you need to lie down during the day? 1 2 3 4
Do you wake up during the night because of pain? YES NO
Do you feel rested in the morning? YES NO
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:
_____
_____
_____
_____

Doctor Initials: _____