Date:_____/_____/_____

Since your last appointment …

Patient Name:_____ DOB:_____/_____/_____ MRN:_____

Any new medical conditions or problems? ☐ No
☐ Yes: _____

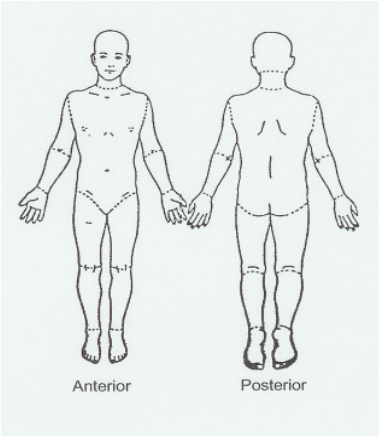
Any new allergies? ☐ No
☐ Yes: _____

Any new medications or changes in medications? ☐ No
☐ Yes: _____

Any changes in family history or social history? ☐ No
☐ Yes: _____

Any new surgeries/fractures? ☐ No ☐ Yes (Please include dates): _____

Where is your pain today? Please Mark it on the diagram below.



Please circle any of the following that describe your pain today:
Is it: ☐dull ☐aching ☐sharp ☐shooting ☐burning
Is it: ☐ constant ☐ intermittent?

Have you had any new treatments for this pain since your last visit? ☐ No ☐ Yes:_____

Please rate the level of your pain **right now** (circle a number):

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
None ……Bearable……Intolerable

What helps pain? _____
_____
What makes it worse? _____
_____

Please rate the maximum level of your pain (circle a number):

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
None ……Bearable……Intolerable

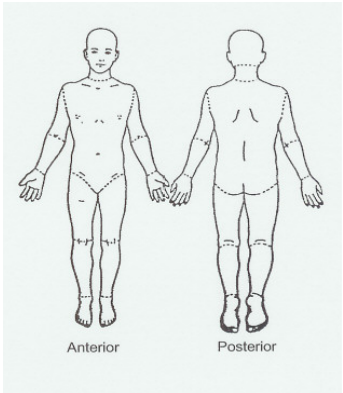
Are you seeing any new physicians in relation to any new medical conditions?
☐ No
☐ Yes If yes, who? _____

Patient Signature:_____ Date: _____

PLEASE SEE BACK TO COMPLETE FORM!!!!

- for office use only -

Provider Notes:



Physician signature: _____ Date: _____

Review of Systems

Neurologic:

Yes	No		Yes	No	
☐	☐	Numbness	☐	☐	Fainting
☐	☐	Tingling	☐	☐	Lack of coordination
☐	☐	Weakness	☐	☐	Tremors
☐	☐	Muscle twitching	☐	☐	Problems walking
☐	☐	Muscle shrinkage	☐	☐	Loss of balance
☐	☐	Muscle cramps	☐	☐	Dizziness
☐	☐	Headache	☐	☐	Blackouts
☐	☐	Migraines	☐	☐	Other:

Constitutional:

Yes	No	
☐	☐	Loss of appetite
☐	☐	Fever
☐	☐	Chills
☐	☐	Weight loss
☐	☐	Other:

Musculoskeletal:

Yes	No	
☐	☐	Bone pain
☐	☐	Other:

EENT:

Yes	No		Yes	No	
☐	☐	Double vision	☐	☐	Hearing loss
☐	☐	Failing vision	☐	☐	Ear drainage
☐	☐	Blurry vision	☐	☐	Hoarseness
☐	☐	Wear glasses	☐	☐	Nose bleeds
☐	☐	Color Blindness	☐	☐	Other:

Hematologic:

Yes	No	
☐	☐	Excessive bleeding
☐	☐	Easy bruising
☐	☐	Other:

Cardiovascular:

Yes	No	
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Other:

Gastrointestinal:

Yes	No		Yes	No	
☐	☐	Nausea	☐	☐	Abdominal pain
☐	☐	Vomiting	☐	☐	Other:
☐	☐	Heartburn indigestion			
☐	☐	Blood in stool			
☐	☐	Bowel incontinence			

Respiratory:

Yes	No	
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Cough
☐	☐	Other:

Endocrine:

Yes	No	
☐	☐	Fatigue
☐	☐	Intolerance to heat
☐	☐	Intolerance to cold
☐	☐	Ankle swelling
☐	☐	Other:

Genitourinary:

Yes	No		Yes	No	
☐	☐	Urinary incontinence	☐	☐	Urinary urgency
☐	☐	Urinary hesitancy	☐	☐	Urinary frequency
☐	☐	Urinary dribbling	☐	☐	Other

Psychiatric:

Yes	No		Yes	No	
☐	☐	Depression	☐	☐	Confusion
☐	☐	Anxiety	☐	☐	Anger
☐	☐	Weeping	☐	☐	Explosive temper
☐	☐	Personality changes	☐	☐	Other:

I hereby attest that all the information of my Past Medical History, Review of Systems and this Pain Diagram are true and correct to the best of my knowledge.

Patient's Signature*: _____ Date: _____