PERSONAL HEALTH HISTORY FORM—RETURN VISIT

Name:		Date:	SSN:
DOB:	Age:	Male / Female	Right / Left Handed
Current/Recent Sports or Physical Activity:			
If patient is a minor, name of adult with him/her today:			*Relationship:*

REASON FOR TODAY'S VISIT

*Please answer **all** questions that apply.*

What has changed since your last visit?

Are your symptoms SAME / BETTER / WORSE / ?(circle) If better, what percent better?
Please explain:

What **NEW** treatments (e.g. medicines, braces/splints, self-directed therapy at home or supervised physical therapy) have you already tried? What has or has not worked?

Does it hurt? Y / N	If so, exactly where does it hurt?	Any numbness or tingling? (if so where?):	
Does the pain travel/radiate? Y / N	If so, where?		
Scale of 0-10, 10 being the worst pain imaginable:	Right Now:	At its best:	At its worst:
Is it constant or sporadic?	Describe:		
What kind of pain is it? (e.g. sharp, dull, aching, electrical, throbbing, etc.)			
Is there pain at night? Y / N	Does it wake you up? Y / N		
What makes the pain better?			
What makes the pain worse?			
Have you had any **new** tests because of this problem such as an MRI, x-rays, blood work, etc. since we saw you last? What were the results?			

NEW SYMPTOMS SINCE LAST VIST

*Please answer for each symptom Y or N. Only check **yes** if this is a new problem since your last visit and explain below.*

	Y	N		Y	N		Y	N
Sudden vision changes			Frequent cough			Easy bruising or bleeding		
Sudden hearing changes			Coughing up blood			Change in appetite		
Nose, sinus, mouth, or throat problems			Fevers or severe chills			Weight loss or gain		
Dizziness			Night sweats			Extreme fatigue or weakness		
Fainting or loss of consciousness			Chest pain			Change in sleeping pattern		
Convulsions or seizures			Heart beat changes			Difficulty tolerating stress		
Frequent or severe headaches			Swelling of hands or feet			Depression		
Swollen lymph glands			Heat or cold intolerance			Problems involving work		
Skin disease or rash			Change in urine patterns			Significant joint pains, stiffness, or swelling (circle)		
skin changes			Change in bowel movements			Other:		
Other Shortness of breath			Abdominal pain or bloating			Other:		

ADDITIONAL NOTES

Name:________________________________ DOB:__________________ Date:________________________________

CURRENT OR PAST MEDICAL CONDITIONS

Has **anything changed** since your last visit? Otherwise, leave blank.

MEDICATIONS

Has **anything changed** since your last visit? Otherwise, leave blank.

MEDICINE ALLERGIES

Has **anything changed** since your last visit? Otherwise, leave blank.

HEALTH RELATED HABITS

Has **anything changed** since your last visit? Otherwise, leave blank.
(Tobacco, alcohol, or drug use; exercise or activities; etc.)

FAMILY HEALTH HISTORY

Has **anything changed** since your last visit? Otherwise, leave blank.

Has any of the following information changed? If so, please make the appropriate corrections. Otherwise, leave blank.

Address:	City:	State/Zip:
Highest/Current Education Level :	Current/Last Occupation:	Employer/School:
Job physical activity requirements:	*If Disabled, list reason:*	
Spouse's name (Adults):	If none, are you: Single Divorced Widowed	
Best Daytime Contact #	Best Evening Contact #	Cell Phone #
Best Contact Email Address:		
Primary Care Physician:	Referring Physician:	