

Swedish Spine, Sports & Musculoskeletal Medicine

www.swedish.org/spinesports

This form will help your doctor understand your concerns and provide the best care possible.			
FOLLOW UP MEDICAL HX FORM			
Name: Age: RT / L	F Handed? L&I# (if applicable):		
What problem/issue brings you here today?	How long has it been bothering you?		
Since your last doctor visit are your symptoms / Better / What makes it better?	Worse / The Same /		
What makes it worse?			
What would you like to accomplish at today's visit?			
Please mark on the line below to describe the level of pain/discomfort y No Pain	ou are having today. Worst Pain Ever		
0 1 2 3 4 5 6 7 8 Please circle or describe what your pain feels like: Dull / Achy / Burning / Stabbing / Numbness / Tingling / Pull Please circle or describe the timing of your pain: Constant / Comes and Goes / Getting Worse / Getting Better Please circle if you have any of the following: Weakness / Incontine			
Weakings / medium	The (Dower of Diadder Issues) / Dalance Tobletis		
What are you doing for exercise now? (including any home program)	Please draw where you have pain or discomfort: Numbness **** Tingling +++ Achy >>> Stabbing ///// Pins & Needles oooooo		
What were you doing that you can no longer do because of your injury?	Fig. 1		
Pain Medication: What medication are you currently taking for pain?			
Are there any side effects from the meds?			
Pain level when taking the meds? Pain level when NOT taking the meds?			
How has the medication helped you beside providing pain relief?			
Have you been taking the medication as prescribed?			
What type of treatment have you had since your last visit? (Circle)			
Physical Therapy Chiropractic Occupational Therapy Massage Accupuncture Other:			

Please circle any of the symptoms listed below that you have had since your last visit with us:

IIau	Since your last visit with t	15.	
unintentional weight gain	vision changes	fevers	change in appetite
generalized morning stiffness	double/blurry vision	fatigue	difficulty swallowing
limb or joint swelling	increased thirst	chest pain	dizziness
urinary frequency	chest palpitations	wheezing	night pain
urinary urgency	high blood pressure	nausea	anxiety
shortness of breath	unexplained cough	vomiting	headache
excessive bleeding	depressed mood	black stools	numbness / tingling
easy bruising	sleep problems	heartburn	new rash/psoriasis
reflux			
If applicable : are you pregnar	nt, trying to get pregnant, or brea	stfeeding?	
PLEASE ONLY F	ILL OUT ANY <u>NEW</u> INFOR	RMATION SINCE Y	OUR LAST VISIT WITH US
Any changes to your medications			
Any NEW med allergies since you	last visit?		
Any NEW medical problems, surge	eries, or tests (lab, EKG, etc) since	ce your last visit?	
Any changes to your family medical	al history?		
Ally changes to your ranny medica	al filstory:		
Date you last worked:	Regular duty / Modi	fied duty / Not working	
The above information is to			
Your Signature:		-	ate:
MD Signature:		ate:	
	This box for OFFICE USE	only	
			•