SWEDISH
MEDICAL GROUP

Patient Label Here

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 / LT 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 / Worse / The Same /

What makes it better?

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 you are having today.

No Pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Please circle or describe what your pain feels like:

Dull / Achy / Burning / Stabbing / Numbness / Tingling / Pulling / Cramping / Tightness

Please circle or describe the timing of your pain:

Constant / Comes and Goes / Getting Worse / Getting Better / Awakens Me at Night

Please circle if you have any of the following:

Weakness / Incontinence (Bowel or Bladder issues) / Balance Problems

What are you doing for exercise now?
(including any home program)

What were you doing that you can no longer do because of your injury?

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?

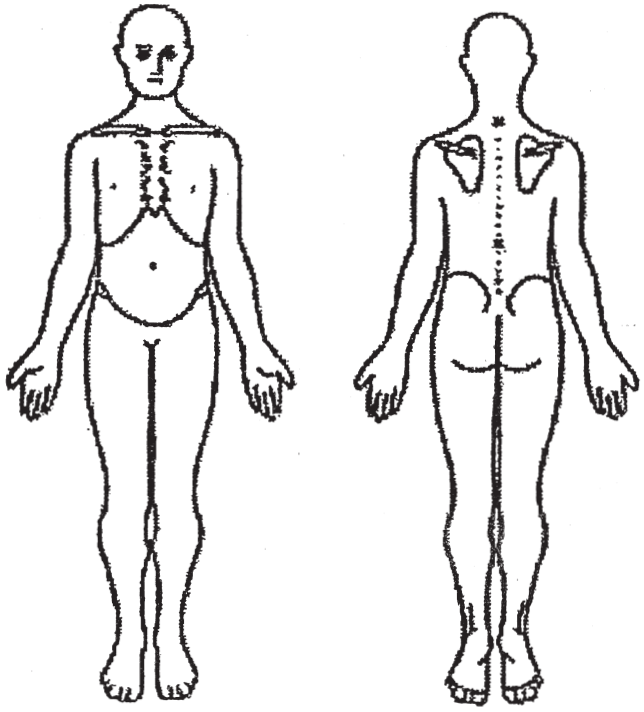
What type of treatment have you had since your last visit? (Circle)

Physical Therapy | Chiropractic | Occupational Therapy

Massage | Accupuncture | Other:

Please draw where you have pain or discomfort:

Numbness **** Tingling +++
Achy >>> Stabbing /////
Pins & Needles oooooo



PLEASE TURN OVER

Patient Label Here

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

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 pregnant, trying to get pregnant, or breastfeeding?

PLEASE ONLY FILL OUT ANY NEW INFORMATION SINCE YOUR LAST VISIT WITH US

Any **changes** to your medications since your last visit? (Include both newly prescribed or discontinued)

Any **NEW** med allergies since your last visit?

Any **NEW** medical problems, surgeries, or tests (lab, EKG, etc) since your last visit?

Any changes to your family medical history?

Date you last worked: Regular duty / Modified duty / Not working

The above information is true and correct to the best of my belief.

Your Signature: Date:

MD Signature: Date:

This box for OFFICE USE only