History of Present Illness-follow up

Name: _____ DOB: _____ Date: _____

Family Medical History: ☐ No change since last visit ☐ changes: _____

General Health: ☐ Same as last visit ☐ New Diagnosis:_____

Any Medication changes since last visit? ☐ No ☐ Yes: _____

Any new allergies since last visit? ☐ No ☐ Yes: _____

MIPS: Do you use tobacco products? ☐ No ☐ Yes ☐ I quit tobacco usage since my last visit. ☐ Prefer not to say

Do you consume more than 5+ drinks (men)/ 4+ drinks (woman) a day more than twice a year? ☐ Yes ☐ No ☐ Prefer not to say

Have you had a flu shot since August 1, 2016? ☐ I declined immunization or not received ☐ Yes ☐ Prefer not to report

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Chief Complaint for today's visit: _____

Current Pain level on a scale of 0-10: 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Intense Severe

Has your pain changed since last visit? ☐ No change ☐ Increased ☐ Decreased

Any new pain complaints since last visit? ☐ No ☐ Yes: _____

Overall progress since last visit: ☐ Better ☐ Same ☐ Worse

Circle all the pain types you have:

Tightness Stiffness Aches Shooting Sharp/stabbing Dull Tingling Numb Throbbing Burning

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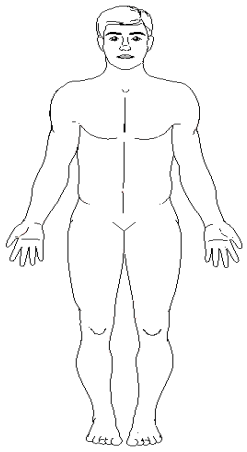
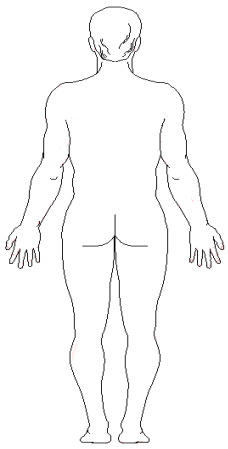
MARK THE DRAWING(S) WITH THE LOCATION OF PAIN YOU ARE EXPERIENCING



Right Left



Left Right

Right

Left

_____ _____

Patient Signature **Date**

For office use only:

Vitals: wt: _____ ht: _____ temp:_____ BP:_____ / _____ Pulse:_____ Resp: _____ Pt refused vitals_____