Follow Up Patient Medical History

History of present illness:
(Please circle the ones that apply.):
What problems brought you to the doctor today? NEW PROBLEM FOLLOW UP OLD PROBLEM

Neck,Back,Shoulder, Elbow, Wrist ,Arm, Hand, Finger, Hip, Knee, Ankle, Foot, Leg, Toe

Other:____

Is this problem: New, Getting better, Getting worse, Chronic, Recurrent,

RATE YOUR PAIN: 0=NO PAIN, 10=SEVERE PAIN : 0--1--2--3--4--5--6--7--8--9--10

How long have you had the problem?____

What makes it better? Heat, Ice, Decrease/Increase activity, Rest, Walking, Elevation
What makes it worse? Heat, Ice, Decrease/Increase activity, Rest, Walking, Elevation
Other?____

Is the pain: Sharp, Stabbing, Dull, Aching, or Just there?

Review of Systems:

Are you having: (please circle):

Cardiovascular: Chest pain, Fainting
Respiratory: Shortness of breath,
Gastrointestinal: Nausea, Vomiting, Diarrhea, Rectal Bleeding
Musculoskeletal: Swelling
Dermatological: Rash/Itching
Neurological: Numbness/Tingling

Please list any changes to your medications AND allergies since your last visit: