TUALITY HEALTHCARE
An OHSU Partner

Since your last appointment… date:_____/_____/_____

Patient name: _____ DOB: _____/_____/ _____ MRN: _____

Any new medical conditions or problems?
❒ No
❒ Yes: _____

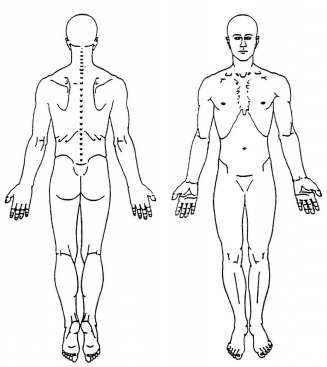
Any new allergies?
❒ No
❒ Yes: _____

Any new medications or changes in medications?
❒ No
❒ Yes: _____

Any changes in family history or social history?
❒ No
❒ Yes: _____

Any new surgeries/ fractures? ❒ No ❒ Yes (please include dates): _____

Where is your pain today (please mark it on the diagram below)?



Please check any of the following that describes your pain today:
Is it: ❒ dull ❒ aching ❒ sharp ❒ shoooting ❒ burning
Is it: ❒ constant ❒ intermittent

Have you had any new treatments for this pain since your last visit?
❒ No ❒ Yes: _____

Please rate the level of your pain <u>right now</u> (circle a number):

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

None. . . . . bearable. . . . . intolerable

What helps the pain:_____

_____

What makes it worse:_____

_____

Please rate the maximum level of your pain (circle a number):

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

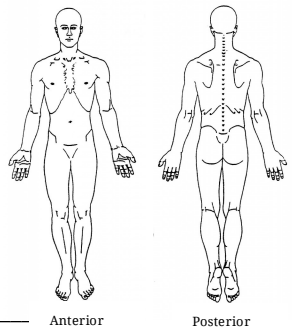
None. . . . . bearable. . . . . intolerable

Are you seeing any new physicians in relation to any new medical conditions?
❒ No
❒ Yes– who: _____

Patient signature: _____ Date: _____

Please see back to complete form

For office use only
Provider notes:



Physician signature: _____ Date: _____

(01/17)

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Review of systems–Please check all that apply

Neurologic

Yes	No	
❒	❒	Numbness
❒	❒	Tingling
❒	❒	Weakness
❒	❒	Muscle twitching
❒	❒	Muscle shrinkage
❒	❒	Muscle cramps
❒	❒	Headache
❒	❒	Migraines
❒	❒	Fainting
❒	❒	Lack of coordination
❒	❒	Tremors
❒	❒	Problems walking
❒	❒	Loss of balance
❒	❒	Dizziness
❒	❒	Blackouts

❒ Other:

EENT

Yes	No	
❒	❒	Double vision
❒	❒	Failing vision
❒	❒	Blurry vision
❒	❒	Wear glasses
❒	❒	Color blindness
❒	❒	Hearing loss
❒	❒	Ear drainage
❒	❒	Hoarseness
❒	❒	Nose bleeds

❒ Other:

Gastrointestinal

Yes	No	
❒	❒	Nausea
❒	❒	Vomiting
❒	❒	Heartburn indigestion
❒	❒	Blood in stool
❒	❒	Bowel incontinence
❒	❒	Abdominal pain

❒ Other:

Genitourinary

Yes	No	
❒	❒	Urinary incontinence
❒	❒	Urinary hesitancy
❒	❒	Urinary dribbling
❒	❒	Urinary urgency
❒	❒	Urinary frequency

❒ Other:

Constitutional

Yes	No	
❒	❒	Loss of appetite
❒	❒	Fever
❒	❒	Chills
❒	❒	Weight loss

❒ Other:

Hematologic

Yes	No	
❒	❒	Excessive bleeding
❒	❒	Easy bruising

❒ Other:

Respiratory

Yes	No	
❒	❒	Shortness of breath
❒	❒	Wheezing
❒	❒	Cough

❒ Other:

Musculoskeletal

Yes	No	
❒	❒	Bone pain

❒ Other

Cardiovascular

Yes	No	
❒	❒	Chest pain
❒	❒	Palpitations

❒ Other:

Endocrine

Yes	No	
❒	❒	Fatigue
❒	❒	Intolerance to heat
❒	❒	Intolerance to cold
❒	❒	Ankle swelling

❒ Other:

Psychiatric

Yes	No	
❒	❒	Depression
❒	❒	Anxiety
❒	❒	Weeping
❒	❒	Personality changes
❒	❒	Confusion
❒	❒	Anger
❒	❒	Explosive temper

❒ Other:

I hereby attest that all the information of my past medical history, review of systems and pain diagram are true and correct to the best of my knowledge.

Patient signature: _____ Date: _____