Re-Exam Patient Health History

(PLEASE PRINT)

Patient's Personal Info

Patient's Full Name: _____ Date of Birth: _____ Age: _____

Patient/Guardian Signature: _____ Today's Date: _____

Parent/Legal Guardian Name (if applicable): _____

Billing Address: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Main Complaint: REQUIRED

Main area of pain today: _____ Intensity 0-10: _____

Pain radiates/spreads into:_____

Please check the following symptoms that you are feeling:

☐ - Dull ☐ - Sharp ☐ - Throbbing ☐ - Burning ☐ - Deep ☐ - Aching ☐ - Tingling ☐ - Stabbing

☐ - Cramping ☐ - Numbness ☐ - Radiating ☐ - Stiffness ☐ - Weakness ☐ - Other _____

Please circle how frequently you are feeling these symptoms: Daily/Weekly/Monthly

0% ---------- 25% ---------- 50% ---------- 75% ---------- 100%

How did your problem begin? _____

Approximant Onset Date: _____

Condition is aggravated by:_____

Condition is relieved by:_____

Day/time when your pain is worse or better? _____

Anything else we should we know about your current condition?_____

_____

Additional Complaints: _____ Intensity 0-10: _____

Have you had any changes to your health history since you were last seen at this office? (E.g. surgeries, major injuries or illnesses, pregnancies, etc.)

If none, check here: ☐ If yes, please describe below.

Event:_____ Date:_____

Event:_____ Date:_____

Event:_____ Date:_____

Event:_____ Date:_____

Event:_____ Date:_____

Medications & Nutritional Supplements

Current medications and/or nutritional supplements, including frequency and dosage *if known*.

If there are no current medications or supplements, check here: ☐

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

_____ Start Date: _____

Allergies

List any known allergies you have:_____

If no allergies are known, check here: ☐

Smoking Status

Do you currently smoke tobacco of any kind? ☐ Smoker ☐ Former Smoker ☐ Never been a smoker