PATIENT HISTORY UPDATE FORM

PLEASE COMPLETE THIS FORM SO THAT WE MAY KEEP OUR RECORDS CURRENT

□ NEW PROBLEM □ EXISTING PROBLEM

NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

WHEN WAS YOUR LAST VISIT TO JYI? _____ PHYSICIAN _____

WHAT ARE WE SEEING YOU FOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS THE SEVERITY OF YOUR PAIN? CIRCLE ONE NONE 0 1 2 3 4 5 6 7 8 9 10 HORRIBLE

IS YOUR PAIN □ IMPROVING □ WORSENING □ STAYING THE SAME □ _____

WAS THERE AN EVENT THAT YOU BELIEVE CAUSED OR IS ASSOCIATED WITH YOUR PROBLEM? □ YES □ NO

IF YES, WHAT HAPPENED? _____

_____

IS THERE ANYTHING THAT RELIEVES OR WORSENS YOUR SYMPTOMS? □ YES □ NO
IF YES, WHAT? _____

HAVE YOU TRIED ANY OF THE FOLLOWING? SPECIFY LENGTH OF TIME AND TYPE

□ BRACING □ CANE □ WEIGHT LOSS _____LBS □ THERAPY HOW LONG? _____

INJECTIONS: □ STEROID LAST: _____ HOW MANY? _____
□ VISCO (SYNVISC, EUFLEXXA, ETC) LAST: _____ HOW MANY? _____

ANTI-INFLAMMATORY MEDICATION (PREVIOUS AND CURRENT - ALEVE/NAPROXEN, IBUPROFEN, CELEBREX, MOBIC, ETC)

_____

HAVE YOU HAD ANY STUDIES, TESTS OR X-RAYS PERFORMED ELSEWHERE RELATED TO THIS PROBLEM?
□ YES □ NO IF YES, WHAT? _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD SINCE YOUR LAST VISIT TO JYI: _____

_____

PLEASE LIST ALL CONDITIONS YOU HAVE DEVELOPED SINCE YOUR LAST VISIT TO JYI: _____

_____

IF A MEDICATIONS/ALLERGIES LIST IS ATTACHED, PLEASE REVIEW AND UPDATE AS NECESSARY.

SIGNATURE _____ **DATE** _____

PHYSICIAN REVIEW _____ **DATE** _____