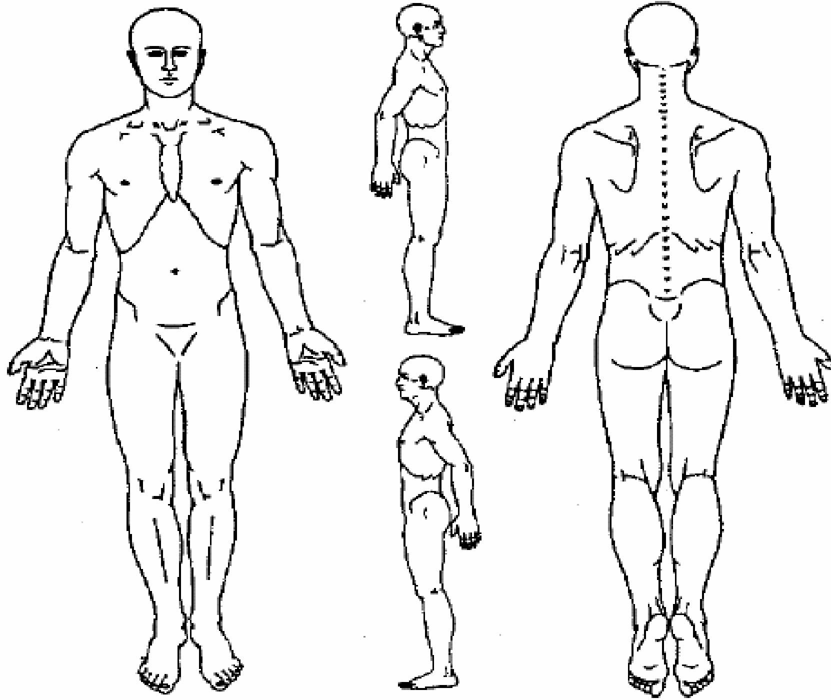
PATIENT EVALUATION

Name: ______________________________________ Date: ________________

BP: R_____/L_____ P:______ R:_____ SaO2:____ Temp:____ Wt:_____

Please use these symbols to describe your pain on the body:
● = Dull/Ache O = Sharp X = Burning + = Running



Please rate your pain from 1 -10, 10 being the worst, to indicate the intensity of your pain:

Without medications: 1 2 3 4 5 6 7 8 9 10

With medications: 1 2 3 4 5 6 7 8 9 10

Have you been seen by any other clinical specialist/physician since your last visit?

____

Have you received any new medications from any other source (hospital or doctor)?

____

Did you bring your medications with you? (Circle One) YES NO

Please let us know how you are/or have been feeling to help us better treat you today:

____

____

____

Name: ________________________________ Date:_______________

REVIEW OF SYSTEMS

____ Unwanted, unexplained weight change
____ Fever
____ Sleeping problems

____ Blurred vision

____ Ringing ears
____ Vertigo

____Chest Pain
____ Shortness of breath
____Swelling (including ankles)
____ Irregular Heart Rate
____ Wheezing

____Abdominal Pain
____Nausea
____Vomiting
____Constipation
____ Diarrhea
____Blood in stool

____Numbness: Where? ________________________
____Tingling: Where? ________________________
____Weakness: Where? ________________________

____Bowel Changes
____Bladder Changes

____Rash

____Depression
____Anxiety
____Suicidal ideations

Females:
Menopause: YES or NO
If Yes, What AGE _______
*If NO when was your Last Menstrual Period ____*_______

Have you had any serious injuries (PAST OR CURRENT)? YES or NO
If Yes please list what was injured and when:

____

____

Have you had any new tests, procedures, surgeries since you last visit with us? YES or NO
If YES please list below and when:

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____

Have you been diagnosed with any new condition since you were here?

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