

RETURN PATIENT INFORMATION QUESTIONNAIRE

Patient Label

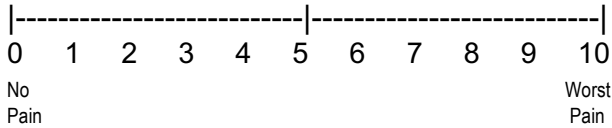
Name _____

Has your pain changed since last visit? _____

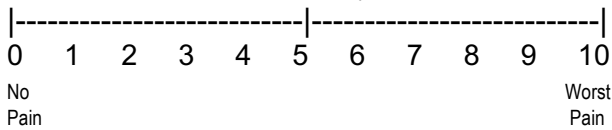
Circle the words below that describe your pain:

Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Occasional
Prickling	Dull	Shooting	Frequent
Numbing	Cramping	Stinging	Rare

Pain **with** medications/therapy:



Pain **without** medications/therapy:



Review of Systems

Circle all past/present symptoms:

Constitutional:

Appetite Change	Chills	Sweating
Fever	Fatigue	Weight Change

HENT

Neck pain	Neck Stiffness	Ear Pain
Sore Throat	Congestion	Sinus Pressure

Eyes:

Eye Pain	Blurred Vision	Double Vision
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Respiratory:

Apnea	Shortness of breath	Cough
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Cardiovascular:

Chest pain	Swelling	Palpitations
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Gastrointestinal:

Nausea/Vomiting	Constipation	Diarrhea
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Endocrine:

Thyroid problems	Elevated glucose	Sexual difficulties
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Genitourinary:

Incontinence	Hesitancy	Urgency
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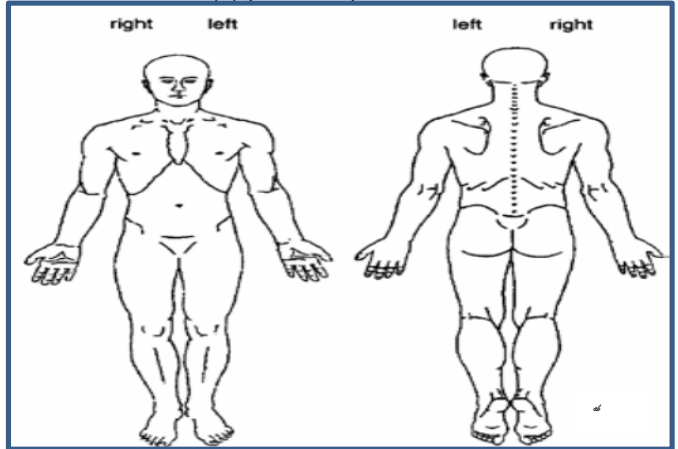
Musculoskeletal:

Arthralgia	Back Pain	Gait Disturbance
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Skin:

Color Changes	Rash	wounds
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Shade the location(s) you have pain:



Past Medical History- Update

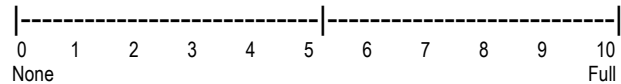
List new allergies: _____

Work Status: _____

Any changes with your health since last visit _____

List changes in medications since last visit _____

Circle the number to describe your average daily function



Allergy/Immunology:

Immunocompromised	Food allergies	Recent infection
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Neuro:

Headache	Dizziness	Numbness
Weakness	Confusion	Seizures

Hematologic:

Anticoagulation	HIV	Bleeding disorder
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Psychiatric:

Depression/anxiety	Substance abuse	Suicidal thoughts
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Provider Notes

HR: ___ BP: ___ RR: ___ Sat ___ Wt ___ T ___