Update Health Information

General Information

Patient Name _____
Mailing Address _____
Home & Cell # Hm:_____Cell:_____
Emp.name/address/phone_____
_____

For Office Use Only
Account Number _____
Date:_____
Patient Height _____
Patient Weight _____
Patient Blood Pressure _____

Race (circle only 1) American Indian-Alaska Native
Asian-White-Black or African American
Native Hawaiian- Other Pacific Islander-Declined to State

Ethnicity (circle only 1) Declined to State-Hispanic or Latino-Not Hispanic or Latino
Preferred Language _____
Email Address _____
Smoking Status (circle only 1) Current Every Day Smoker-Current Some Day Smoker-Former Smoker-Never Smoker
Emergency Contact Name_____ Phone #_____

Do you have any allergies to medication? Yes No (If Yes, please indicate below)
Allergy: _____ Allergy: _____Allergy: _____Allergy:_____
Are you currently taking any medication? Yes No (if yes, please list on back of this form)

Have you had any surgeries? Yes No (if yes, please list and include the approximate date of surgery)_____
_____

Briefly describe the reason for your visit today:_____
_____

Have you seen anyone else for this condition? Yes No (if yes, who?)_____

List in order of severity the symptoms you are experiencing today: Choose the severity level associated with each symptom

1._____❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) (10) Remarkably Severe
Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None
Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

2._____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None
Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

3._____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None
Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

4._____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None
Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

PATIENT / GUARDIAN SIGNATURE:_____ DATE:_____