

Patient Health Assessment (cont.)

Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in upper leg or hip.....	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness/lump.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in lower leg or knee.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Conditions.....	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ankle or foot.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/stiffness of joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight gain/loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
General prolonged fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	Prostate condition.....	<input type="checkbox"/>	<input type="checkbox"/>
Condition of uterus/ovaries.....	<input type="checkbox"/>	<input type="checkbox"/>			

Tobacco Use:

- Past Present
 Occasional Moderate Heavy

Alcohol use:

- Past Present
 Occasional Moderate Heavy

Caffeine use: (Coffee, tea, soft drinks)

- Past Present
 Occasional Moderate Heavy

Pregnancy: Past Present

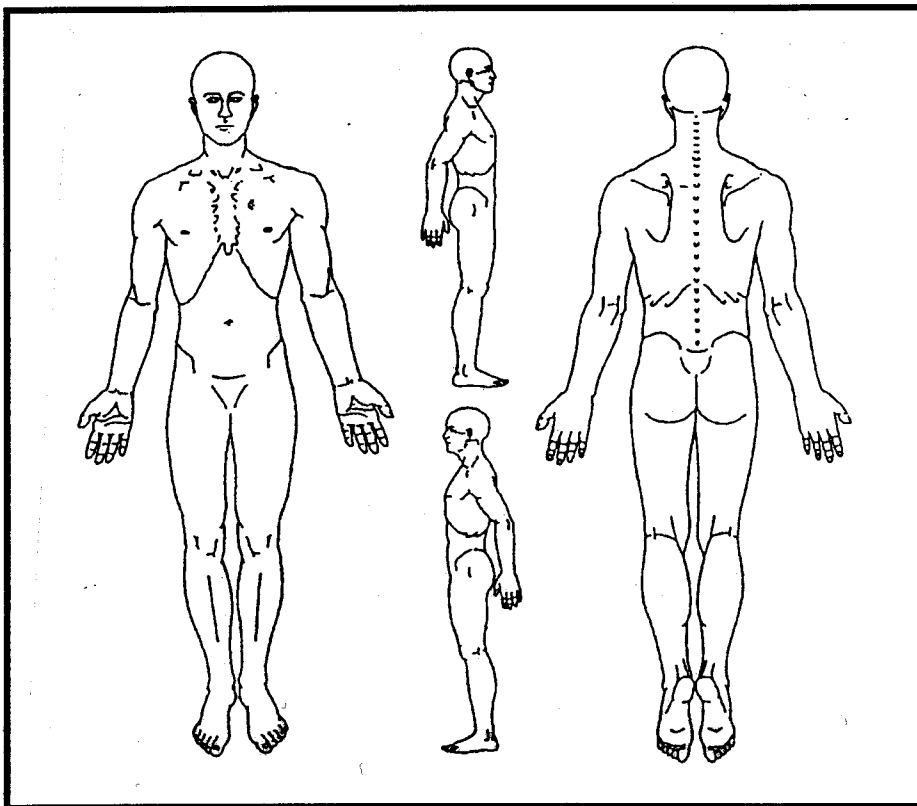
Surgical Procedure:

- Past Present

Please list: _____

Comments: _____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

 Patient Name

 Provider Initials

 Date