



PHOENIX Emergency Care

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ESTABLISHED PATIENT UPDATE OF MEDICAL HISTORY

To best serve your health care needs it is valuable to have an account of changes and developments in your health status since your last visit. Please answer all questions to the best of your ability.

(For office use only)

Vital signs: HT _____ WT _____ Temp _____ O2% _____ HR _____ RR _____ B/P _____ BMI _____

Allergy Testing information provided Yes _____ Tobacco Use Counseling provided Yes _____ N/A _____

NAME: _____ DOB _____ Age _____ Date _____

Medication Allergies: _____

REASON FOR TODAY'S VISIT: _____

Is this a work related incident? Yes _____ No _____ If yes, please notify the front desk.

When did this problem begin? _____

Has the problem become? Better _____ Worse _____ Stayed the same _____

What makes it better? _____

What makes it worse? _____

Have you had this problem before? Yes ___ No ___

If yes, what was the diagnosis? _____

What was the treatment? _____

What was the result? Better _____ Worse _____ Resolved _____ No Effect _____

Do you have pain? Yes _____ No _____ If yes, Where? _____

Describe the pain: sharp _____ dull _____ throbbing _____ aching _____ burning _____ cramping _____
other _____

Rate the level of pain: mild: 1 2 3 moderate: 4 5 6 severe: 7 8 9 10

Is the pain: constant _____ comes and goes _____ moves _____ (to where) _____

SOCIAL HISTORY:

Caffiene Use: Yes No If yes: how many cups per day? _____
Alcohol Use: Yes No If yes: how many drinks? Daily Weekly Monthly Occasionally
Tobacco Use: Yes No If no: when did you quit? _____
If Yes: For how many years? ____ Every day ____ Occasionally ____
How many? 1-9 10-19 20- 39 40 or more
Recreational Drug Use: Yes No If yes: describe _____

System Review: (Check those that apply to you TODAY.)

General: fever chills sweats muscle aches weakness fatigue
insomnia heat/cold intolerance thirst change in weight change in appetite
Skin: rash lesions sores moles bleeding tendencies
Head: headache loss of consciousness seizure history of head trauma dizziness
Eyes: change in vision pain redness irritation tearing Pain from bright light
Ears, Nose & Throat: hearing loss ear pain ringing in ears vertigo (spinning/dizziness)
nosebleed snoring postnasal drip sore throat runny nose
Respiratory System: shortness of breath wheezing chest pain coughing up mucus
dry cough
Lymph Nodes: swollen painful
Cardiovascular: Chest Pain palpitations fainting shortness of breath ankle swelling
use ____ pillows when laying flat leg/calf cramps
Gastrointestinal: heartburn bloating belching flatulence nausea vomiting
abdominal pain blood in bowel movement change in bowel habits constipation
diarrhea blood in vomitus
Genitourinary: frequent urination pain with urination urinate ____ times at night
difficulty starting stream blood in urine
Female: No. Preg. ____ No. Live births ____ No. Child. living ____
Last menstrual cycle ____ Hysterctomy/menopause age ____ On hormones Y N
no periods irregular Periods regular periods bleeding between periods
heavy period vaginal discharge painful intercourse
Breasts: swelling lumps pain/tenderness discharge from nipple
regular self-examination? Y N
Musculoskeletal: neck pain back pain joint pain joint swelling bodyaches muscle spasms
Neurological: weakness tremor numbness tingling memory loss
difficulty with walking or talking
Psychological: depression anxiety difficulty concentrating thoughts of harm to self or others

Name of your pharmacy: _____ Phone: _____

Please notify the front desk if any of the following has changed since your last visit:

Phone number: _____

Address: _____

Insurance: _____

Signed : _____