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_____ 02%_____ 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 Other Choose....
Respiratory System: ☐ shortness of breath ☐ wheezing ☐ chest pain ☐ coughing up mucus other
☐ 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 With your freque
☐ 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 :_____