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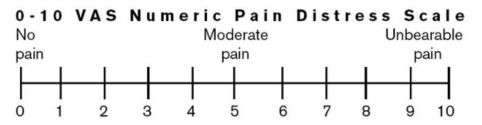
**Established Patient Questionnaire Form**

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

1. Any changes in past medical history? [ ] YES [ ] NO
   * If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Any changes in medications? [ ] YES [ ] NO
   * If yes, please list any changes in medications. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Any changes in allergies? [ ] YES [ ] NO
   * If yes, please list any new allergies. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Rate your pain as:
   * [ ] improving [ ] unchanged [ ] worsening



**Review of Systems**

**Please check the box if you are currently experiencing any of the following:**

**General:** [ ] Loss of appetite, [ ] Recent weight loss, [ ] Fatigue, [ ] Fever or chills, [ ] Weakness

**Respiratory**: [ ] Shortness of breath, [ ] coughing, [ ] coughing blood, [ ] difficulty breathing, [ ] wheezing

**Cardiovascular**: [ ] chest pain, [ ] tightness, [ ] palpitations, [ ] swelling, [ ] difficulty breathing lying

**Head/Eyes/Ears/Nose/Throat**: [ ] Headaches, [ ] neck pain, [ ] decreased hearing, [ ] ringing in ears, [ ] vision changes, [ ] Glaucoma, [ ] cataracts, [ ] blurry/ double vision, [ ] itching nose, [ ] sinus pain, [ ] nosebleeds, [ ] dentures, [ ] mouth sores/bleeding, [ ] sore throat, [ ] dry mouth

**Neurological**: [ ] Dizziness, [ ] fainting, [ ] seizures, [ ] numbness, [ ] tingling

**Gastrointestinal**: [ ] Nausea, [ ] Vomiting, [ ] Constipation, [ ] diarrhea,[ ] difficulty swallowing,[ ] heartburn

**Endocrine**: [ ] Sweating, [ ] Frequent urination, [ ] Excessive thirst, [ ] change in appetite

**Psychiatric**: [ ] nervousness, [ ] stress, [ ] depression, [ ] memory loss

**Skin**: [ ] Rashes, [ ] Itching, [ ] dryness, [ ] Hair and nail changes, [ ] skin color changes

**Kidney/Bladder/ Urine**: [ ] Frequency, [ ] urgency, [ ] burning or pain, [ ] blood in urine, [ ] incontinence

**Musculoskeletal:** [ ] Muscle and joint pain, [ ] stiffness, [ ] back pain, [ ] swelling of joints

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**Signature of patient or patient’s parent/ legal guardian Date**

**Medical History Acknowledgement**