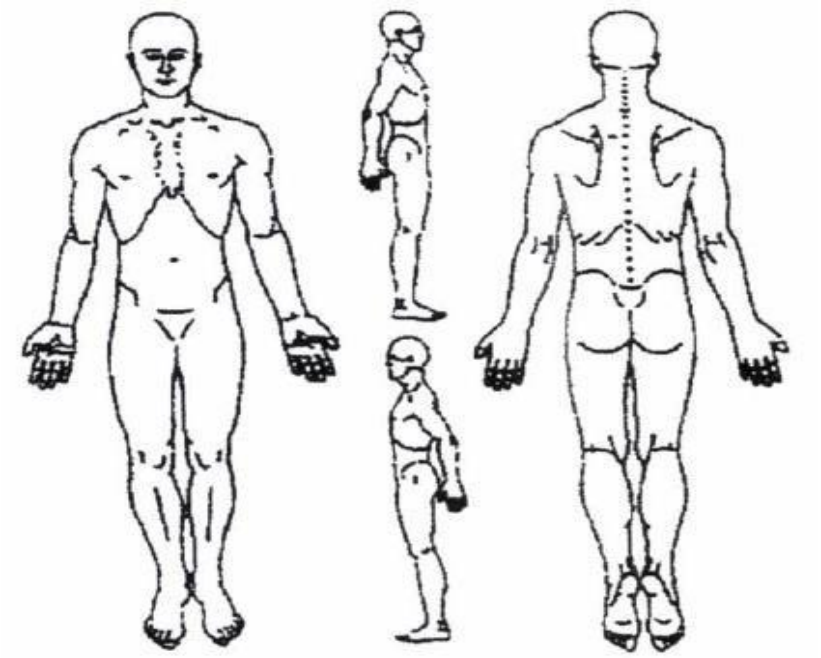
ASAP
ADVANCED SPINE AND PAIN

1715 N. George Mason Dr #102 ~ 2296 Opitz Blvd #210 ~ 450 Garrisonville Rd #109 ~ 1499 Chain Bridge Rd #101 ~ 11230 Waples Mill Rd #114C ~ 3500 Boston St #J1
Arlington, VA 22205 Woodbridge, VA 22191 Stafford, VA 22554 McLean, VA 22101 Fairfax, VA 22030 Baltimore, MD 21224

Follow Up Visit Medical History Form

Patient Name:	DOB:	Date:

Please shade the areas where you are having pain



Please indicate your ***current*** pain
0 1 2 3 4 5 6 7 8 9 10
Please rate your ***worst*** pain in the last week
0 1 2 3 4 5 6 7 8 9 10
Please rate your ***least*** pain in the last week
0 1 2 3 4 5 6 7 8 9 10

What is your main complaint?
If pain is located in the neck or back, does it radiate into your arms or legs? ☐Yes ☐No
Has your usual pain improved since your last visit? ☐Yes ☐No
Please indicate your degree of improvement: _____%
If you had a recent procedure, how much pain relief did you have following it? _____%
Are there any new symptoms since your last appointment?
What words best describe how the pain feels? ☐Sharp ☐Stabbing ☐Burning ☐Throbbing ☐Tingling ☐Aching ☐Deep Pressure ☐Dull ☐Other_____
What makes your pain better? ☐Heat ☐Rest ☐Cold ☐Medication ☐Exercise ☐Other_____
What makes your pain worse? ☐Heat ☐Cold ☐Walking ☐Bending/Twisting ☐Sitting ☐Standing ☐Lying ☐Stress ☐Coughing/Sneezing ☐Standing from sitting

Patient Name:	DOB:	Date:

Review of Systems

Please check any of the following symptoms/problems you have experienced since your last visit

Constitutional:	**Eyes:**	**Ear, Nose, Throat:**	**Cardiovascular:**	**Respiratory:**
☐ NO PROBLEMS ☐ Weight Gain ☐ Weight Loss ☐ Difficulty Sleeping ☐ Fever ☐ Fatigue Other:	☐ *NO PROBLEMS* ☐ Blurred Vision ☐ Double Vision ☐ Eye Pain ☐ Redness and Drainage ☐ Excessive Watering Other:	☐ *NO PROBLEMS* ☐ Nosebleeds ☐ Snoring ☐ Hearing Loss ☐ Ringing in Ears ☐ Dizziness Other:	☐ *NO PROBLEMS* ☐ Chest Pain/Pressure ☐ Irregular Heart Rate ☐ Rapid Heart Rate ☐ Swelling in Legs/Feet ☐ Poor Circulation Other:	☐ *NO PROBLEMS* ☐ Chronic Cough ☐ Wheezing ☐ Shortness of Breath ☐ Coughing up Blood ☐ Home Oxygen Use Other:
Gastrointestinal:	**Genitourinary:**	**Musculoskeletal:**	**Dermatologic:**	**Neurological:**
☐ *NO PROBLEMS* ☐ Constipation ☐ Diarrhea ☐ Nausea/Vomiting ☐ Blood in Stool ☐ Abdominal Pain Other:	☐ *NO PROBLEMS* ☐ Frequent Urination ☐ Incontinence of Urine ☐ Painful Urination ☐ Blood in Urine ☐ Kidney Stone Other:	☐ *NO PROBLEMS* ☐ Joint Pain ☐ Stiffness of Joints ☐ Joint Stiffness ☐ Muscle Spasms/Cramps ☐ Muscle Weakness Other:	☐ *NO PROBLEMS* ☐ Easy Bruising ☐ Itching ☐ Color Change ☐ Rashes ☐ Nail or Hair Change Other:	☐ *NO PROBLEMS* ☐ Fainting ☐ Headache ☐ Poor Memory ☐ Recent Falls ☐ Seizures Other:
Psychiatric:	**Endocrine:**	**FOR OFFICE STAFF ONLY:**		
☐ *NO PROBLEMS* ☐ Excessive Worry ☐ Frequent Sadness ☐ Depression ☐ Feeling Hopeless ☐ Excessive Stress Other:	☐ *NO PROBLEMS* ☐ Heat Intolerance ☐ Cold Intolerance ☐ Changes in Appetite ☐ Abnormal Sweating ☐ Hair Loss Other:	HT: _____ / WT: _____ / BP: _____ Pulse: _____		

Vaccinations:

Have you had a current season flu shot? ____Yes ____ No Month and Year Received _____

If over the age of 65, have you had a pneumonia vaccination? _____ Yes ____ No