GULF COAST BRAIN SPORT & SPINE ADULT RETURN

PT #_____

D.O.B _____

Goals related to this visit:

_____

Please list any new Diagnoses:

_____

Please list any medication changes:

_____

Smoking Status:

_____ packs per day _____ years smoking

Review of Systems: (Please circle all that apply)

General: Weight Change, Fever, Chills, Bleeding, Lumps, Mass, Cancer History

ENT: Visual Change, Hearing Change, Ringing in Ears, Snoring, Congestion, Bleeding Gums, Sensitivity to Light, Sensitivity, to Noise, Change in Taste or Smell

Musculoskeletal: Joint Pain, Morning Stiffness >1 hour or <1 hour, Joint Swelling, Joint Redness, Back Pain, Hand Pain, Hip Pain, Knee Pain, Elbow Pain, Ankle Pain

Neurologic: Seizure, Memory Loss, Concentration Difficulty, Slowed Thinking, Fatigue, Insomnia, Headache, Loss of Balance, Numbness, Saddle Anesthesia.

Cardiovascular: Fainting, chest pain, high blood pressure, swelling

Respiratory: Cough, Wheezing, Snoring, Short of Breath

Endocrine: Cold Intolerance, Heat Intolerance, Excess Sweating, Excess Thirst, Excess Hunger

Gastrointestinal: Abdominal Pain, Reflux, Nausea, Vomiting, Constipation, Diarrhea, Blood in Stool, Incontinence

Genitourinary: Incontinence, Blood in Urine, Poor Urinary Flow

Gynecologic: Pregnancy, Menses, Abnormal bleeding, Pelvic Pain

Psychologic: Depression, Anxiety, Frustration, Stress, Suicidal, Plan to Hurt Self, Plan to Hurt Others

Skin: Rash, Itching

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN SIGNATURE_____ DATE_____