R&O History Form for Established Patients

Name____ Date____________________

Primary Care Physician____

Since your last visit has there been…….

Any medication changes? (please describe)

Any surgeries or procedures? (please describe)

Any tests such as X-rays, CAT scans or MRIs? Where? (please describe)

Anything in your life causing you extra stress? (please describe)

Any lab work done? Where?

Please review the following list. Check any problems which have significantly affected you since your last visit.

- ☐ Belly pain
- ☐ Breathing trouble
- ☐ Change in bowel habits
- ☐ Chest pain
- ☐ Cold or flu symptoms
- ☐ Cough
- ☐ Difficulty swallowing
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Headache
- ☐ Heartburn
- ☐ Indigestion
- ☐ Joint pain
- ☐ Nausea
- ☐ Numbness or tingling
- ☐ Rash
- ☐ Restless legs
- ☐ Skin wound
- ☐ Snoring
- ☐ Trouble sleeping
- ☐ Trouble with urination
- ☐ Vomiting
- ☐ Vision changes
- ☐ Weight changes

On the scale below, circle a number which best describes your situation.

Most of the time, I function…

1	2	3	4	5
Very Poorly	Poorly	OK	Well	Very Well