HEADACHE & PAIN
CENTER OF PALM BEACH

Updated Medical History

Name: _____ **DOB**: _____

Reason for Visit: _____

Which medications are you taking that were prescribed here?_____

_____

Any other changes in medication?_____

Review of Systems

GENERAL: ☐Unexplained Changes in Weight ☐Fever or Chill Sweats ☐Change in Voice ☐Tiredness

NEUROLOGICAL: ☐Head Pain ☐Seizures/Epilepsy ☐Tingling (Pins & Needles) ☐Loss of Consciousness ☐Tremors/Shaking ☐Pinched Nerve ☐Difficulty Walking ☐Weakness/Paralysis ☐Numbness/Loss of Sensation ☐Memory Problems ☐Disorientation ☐Difficulty Speaking ☐Difficulty Swallowing ☐Double Vision ☐Loss of Vision ☐Difficulty Writing ☐Difficulty Reading

HEAD: ☐Headache ☐Head Injury ☐Visual Problems ☐Hearing Problems ☐Vertigo (Dizziness) ☐Ear Pain ☐Tinnitus (Ringing in Ears) ☐Sinus Problems ☐Dental Problems ☐Any Mental Complaints

MUSCULAR / SKELETAL: ☐Muscle Aching ☐Weakness ☐Joint Swelling ☐Joint Pain or Stiffness ☐Neck Pain ☐Arthritis ☐Low Back Pain

SLEEP: ☐Insomnia ☐Snoring (Excessive) ☐Daytime Drowsiness

CARDIAC/VASCULAR/HEART: ☐Chest Pain ☐Palpitations ☐Heart Murmur ☐Fainting ☐Swollen Feet/Legs ☐Blood Vessel

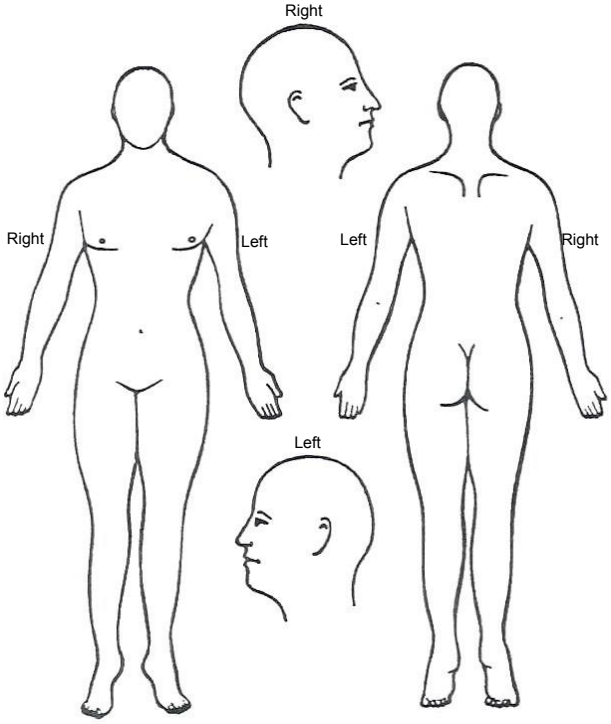
LUNGS: ☐Coughing/Wheezing ☐Shortness of Breath ☐Coughing Up Blood

GASTRO-INTESTINAL: ☐Change in Appetite ☐Digestion Problems ☐Gas ☐Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐Abdominal Pain

GENITAL/URINARY: ☐Difficulty Urinating ☐Incontinence ☐Kidney Stones ☐Infections ☐Impotence ☐Other Sexual Problems ☐Women: Irregular Periods

SKIN/HAIR: ☐Change in Hair ☐Skin or Scalp Lesions ☐Rash ☐Dryness ☐Itching

ENDOCRINE/HEMATOLOGICAL ALLERGY IMMUNE: ☐Sensitivity to Temperature ☐Unusual Thirst or Hunger ☐Excessive Urination ☐Bloating ☐Swollen Glands ☐Pale Color ☐Multiple Allergies ☐Frequent Colds/Infections



Tell Us Where You Hurt

Mark the areas on your body where you feel you pain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > >	**Numbness** = = =	**Pins and Needles** o o o o
Burning x x x x	**Stabbing** / / / /	**Throbbing** ~ ~ ~ ~

Severity: List the region of pain. Circle the severity number 1=least 10=greatest

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

Patient Initials:_____ Date:_____

Reviewed by Physician:_____ Date:_____