AOA SYMPTOM SHEET

PATIENT'S NAME: _____ **DATE:** _____ACCOUNT#

BIRTH DATE: _____ **HEIGHT:** _____ **WEIGHT:** _____ **PHARMACY:** _____

PRIMARY CARE PHYSICIAN: _____

REASON FOR TODAY'S VISIT: _____ _____

Circle all that apply: *Burning Numbness Tingling Swelling Aching*

Date of Accident/Injury: _____ **How Accident/Injury happened:** _____

INDICATE LEVEL AND LOCATION OF PAIN *(INDICATE WITH AN "X" ON THE PICTURE)*

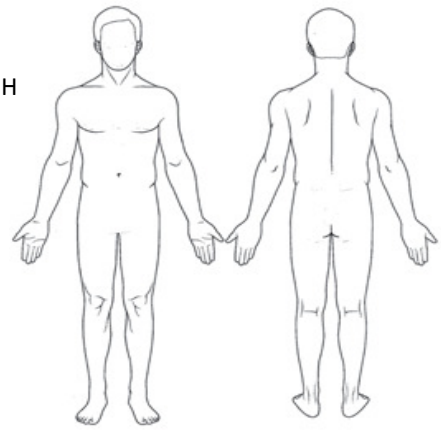
Marital status (please circle): Married Widowed Single Divorced

When was your last:
Flu shot: _____
Pneumovax: _____
Mammogram (if applicable):_____
Colonoscopy: _____

LEVEL OF PAIN:

☐ 10 HIGH
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1 LOW

LOCATION:



SURGICAL HISTORY: LIST ALL PRIOR SURGERIES

1. _____ YEAR _____ COMPLICATIONS _____
2. _____ YEAR _____ COMPLICATIONS _____
3. _____ YEAR _____ COMPLICATIONS _____
4. _____ YEAR _____ COMPLICATIONS _____

CURRENT MEDICATIONS: (please list the reason you take the medication on the line adjacent to dosage)

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

DRUG ALLERGIES OR PROBLEMS WITH MEDICATIONS:

1. _____ 3. _____
2. _____ 4. _____

OFFICE USE ONLY:
PHYSICIAN'S INITIALS _____ DATE: _____