TEXAS SPECIALIST CENTER
PROFESSIONAL ASSOCIATES

Dr. Guse

FOLLOW UP HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Treatment at last visit: _____

_____

Pain has: ○ Increased ○ Decreased ○ Moved ○ Not Changed

Pain location: ○ Left ○ Right○ Bilateral ○ Hip ○ Knee ○ Shoulder ○ Ankle ○ Wrist ○ Other: _____

Pain Character: Mark your pain level? No Pain--- ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 --- Unbearable

Pain is: ○ Sharp ○ Dull ○ Aching ○ Burning Other:_____

Time pain is worse: ○ Night ○ Day ○ Morning ○ Evening ○ Constant Other:_____

Pain worsens with: ○ Walking ○ Standing ○ Sitting ○ Laying ○ Bending ○ Twisting
Other: _____

Pain improves with: ○ Walking ○ Standing ○ Sitting ○ Laying ○ Frequent position change ○ Medication
Other: _____

PAST MEDICAL HISTORY

Since last visit with Dr. Guse have you had: please list dates and details

Accidents/Injuries: _____ ○ None
Hospitalizations: _____ ○ None
Surgeries: _____ ○ None
Medication changes: _____ ○ None
New medical problems: _____ ○ None
New Allergies: _____ ○ None

REVIEW OF SYSTEMS

Have you had any of the following symptoms in the last month? (Choose all that apply)

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					**NONE**	**COMMENTS**
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

_____ _____
Signature **Date**