

# 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: \_\_\_\_\_

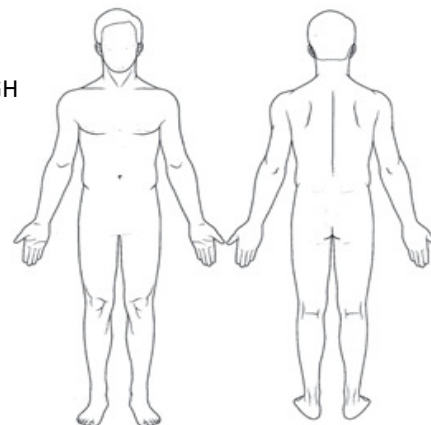
Mammogram (if applicable): \_\_\_\_\_

Colonoscopy: \_\_\_\_\_

LEVEL OF PAIN:

LOCATION:

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



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: \_\_\_\_\_