MakSportsMD - Bim Makinde MD

This form will help your doctor understand your concerns and provide the best care possible.

FOLLOW UP MEDICAL HX FORM

Name _____ Age _____ Right or Left Handed? _____

LNI Claim (if applicable) _____

What problem/issue brings you here today? How long has it been bothering you?

Since your last doctor visit are your symptoms… ☐ Better ☐ Worse ☐ The Same

What makes it better?

What makes it worse?

What would you like to accomplish at today's visit?

Please mark on the line below to describe the level of pain /discomfort you are having today.

No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Pleas select or describe what your pain feels like:

☐ Dull ☐ Achy ☐ Burning ☐ Stabbing ☐ Numbness ☐ Tingling ☐ Pulling ☐ Cramping ☐ Tightness ☐ Other _____

Please select or describe the timing of your pain:

☐ Constant ☐ Comes and Goes ☐ Getting Worse ☐ Getting Better ☐ Awakens Me at Night ☐ Other _____

Please select if you have any of the following:

☐ Weakness ☐ Incontinence (Bowel or Bladder issues) ☐ Balance Problems

What are you doing for exercise now?
(including any home program)

What were you doing that you can no longer do because of injury?

Pain Medication:
What medications are you currently taking for pain?

Are there any side effects form the meds? If so, describe:

Pain level when taking the meds? _____
Pain level when NOT taking the meds? _____

How has the medication helped you besides providing pain relief?

Have you been taking the medication(s) as prescribed? If not, please describe:

Treatments since your last visit?

☐ Physical Therapy ☐ Occupational Therapy

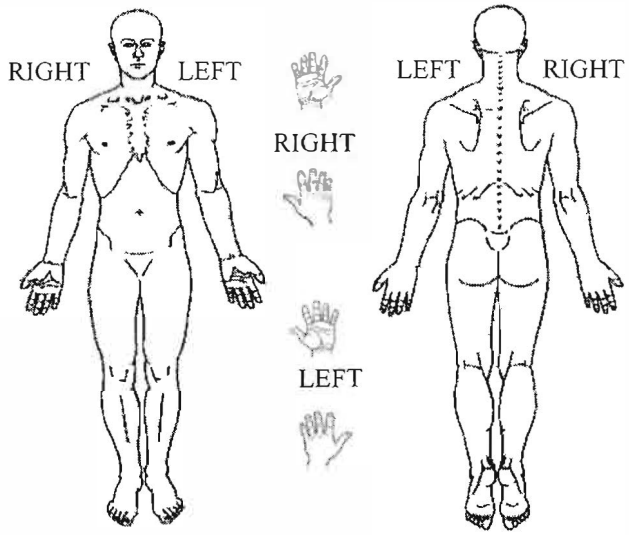
☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other:

Please draw where you have pain or discomfort:

Numbness **** Tingling +++

Achy >>> Stabbing /////

Pins & Needles ooooo



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Please circle any of the symptoms listed below that you have had since your last visit with us:

Unintentional weight gain ☐	Vision changes ☐	Fevers ☐	Change in appetite ☐
Generalized morning stiffness ☐	Double/blurry vision ☐	Fatigue ☐	Difficulty swallowing ☐
Limb or joint swelling ☐	Increased thirst ☐	Chest pain ☐	Dizziness ☐
Urinary frequency ☐	Chest palpitations ☐	Wheezing ☐	Night pain ☐
Urinary urgency ☐	High blood pressure ☐	Nausea ☐	Anxiety ☐
Shortness of breath ☐	Unexplained cough ☐	Vomiting ☐	Headache ☐
Excessive bleeding ☐	Depressed mood ☐	Black stools ☐	Numbness/tingling ☐
Easy bruising ☐	Sleep problems ☐	Heartburn ☐	New rash/psoriasis ☐
Reflux ☐			

If applicable: are you pregnant, trying to get pregnant, or breastfeeding?

PLEASE ONLY FILL OUT ANY NEW INFORMATION SINCE YOUR LAST VISIT WITH US

Any **changes** to your medications since your last visit? (Include both newly prescribed or discontinued)

Any **NEW** medication allergies since your last visit?

Any **NEW** medical problems, surgeries, or tests (lab, EKG, etc) since your last visit?

Any changes to your family medical history?

Date you last worked: ☐ Regular duty Modified duty ☐ Not working

The above information is true and correct to the best of my belief.

Your Signature: Date:

MD Signature: Date:

This box for OFFICE USE only