Dignity Health.
Pacific Central Coast
Health Centers

Higuera Health Center
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San Luis Obispo, CA 93401
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Patient Evaluation Form

Name_______________ Age_______ Sex: M / F Date_______________

MR# (office use)_______________ Date of birth_______/ _______ / _______

Referring Physician_______________ Primary Care Physician_______________

Phone_______________ Pharmacy name_______________

History of Present Illness

Chief complaint _______________

Duration_______months _______ years

History of trauma: Yes / No What kind? _______________

Work related: Yes / No Workman's Comp: Yes / No

Height_______Weight_______

Description of Complaint

Location_______________

Quality_______________

Severity_______________

Duration_______________

Timing_______________

Aggravating factors_______________

Relieved by_______________

Other symptoms_______________

Initial treatment_______________

Response to initial / prior treatment_______________

Pertinent history_______________

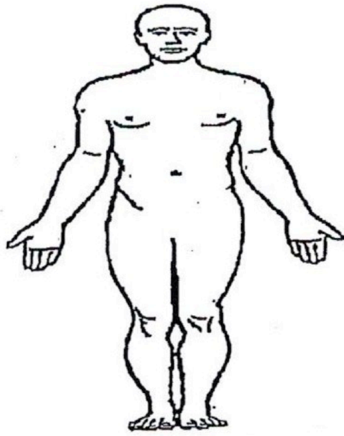
Diagnostic tests done_______________

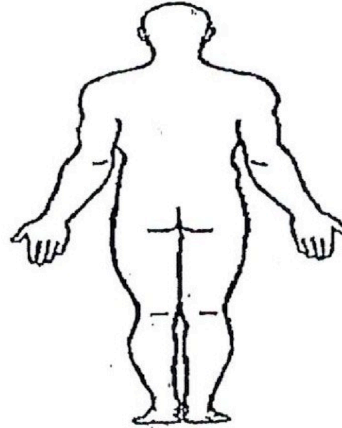
Pain Questionnaire

Mark areas of body affected: Aching: *** Sharp: ooo

Numbness: XXX Pins and needles: III

Burning: -- -- --





How much pain do you have? Pain Scale:

No Pain 0 ________________________ 5 ________________________10 Worst Pain (disabling pain)

Activities affected by pain?

Sleep: Yes / No Walking – Mobility: Yes / No Work: Yes / No

Daily Activities: Yes / No

Review of Systems (Please circle Yes / No)

Weight loss: Yes / No	Weight gain: Yes / No
Vision loss: Yes / No	Double vision: Yes / No
Hearing loss: Yes / No	Difficulty swallowing: Yes / No
Chest pain: Yes / No	Palpitation: Yes / No
Short of breath: Yes / No	Wheezing: Yes / No
Nausea / vomiting: Yes / No	Bowel incontinence: Yes / No
Painful urination: Yes / No	Bladder incontinence: Yes / No
Joint pain: Yes / No	Muscle pain: Yes / No
Numbness: Yes / No	Weakness: Yes / No
Leg swelling: Yes / No	Leg cramps: Yes / No
Back pain: Yes / No	Neck pain: Yes / No

Past Medical History

Please check if you have any of the following:

_____High blood pressure _____Heart disease _____Diabetes

_____Heart failure _____Poor circulation _____Kidney failure

_____Arthritis _____Stroke _____Other__________________

Surgeries____

____

Family Medical History ____

____

Personal / Social History

☐ Employed ☐ Retired ☐ Unemployed ☐ Self-employed ☐ Other________________________

☐ Live alone ☐ Live with family / friend ☐ Group home ☐ House ☐ Apartment ☐ Assisted living

Tobacco use: Yes / No ☐ Former Type of tobacco used_______________Packs per day _______

Years smoked ______________Year quit___________________

Other tobacco units per day (cans, cigars, etc.) ________________________________

Units per day_______________ Years used_________________ Year quit___________________

Do you drink caffeine? Yes / No Type_______________________ Amount daily_______________

Do you drink alcohol? Yes / No ☐ Former

Type______________________________ How much per week______________________________

Amount____________________________ Last drink_________________________

Do you exercise? Yes / No How often__________________Type of exercise__________________________

Drug Allergies

Drug	Severity and Reaction

Medication

Medication / Dosage	Directions