

## PROGRESS REPORT

DATE: \_\_\_\_\_ PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

DAYTIME PHONE NUMBER: (     ) \_\_\_\_\_ HOME PHONE NUMBER: (     ) \_\_\_\_\_

Your Email Address: \_\_\_\_\_, if necessary, should we notify your lab results at this Email address? Yes    No (encircle)

Please note: You can access this form from our web page [www.ehacstl.com](http://www.ehacstl.com) by clicking on button# 6 labeled as Appointment. It will help you to think through your problems that you want to address at the next visit and will also save you the time.

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**1** .Tell us about your successes with treatment, i.e., the symptoms that have improved:

**2. Be a good story-teller:** What problems you want to solve or talk about? What are your major symptoms and problems for which you have come to us today? Please explain. In describing your symptoms, think of duration, i.e., how long you have been having it, how severe it is, its frequency (how often you experience it).

**3.** What seems to aggravate the above symptoms if any, and what seems to relieve them. Are there any other symptoms that you experience along with them. Please explain:

**4.** Overall, the treatment has helped me feel better (circle one)           25%           50%           75%           90%  
100%           No change

**5.** If you are better but not 100%, what symptoms or problems (other than mentioned above under question# 2) should be resolved before you can say you are 100% better?

**6.** What medicines are you currently taking?

**7.** Since your last visit, has there been a change in your insurance, home telephone number or address?

Yes           No           If yes, please give new information:

***PLEASE TURN THE PAGE OVER***

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ROS: In this section, rate each of the following symptoms based upon your typical health profile. POINT SCALE 0 = Never or almost never have the symptoms 1 = Occasionally have it, effect is not severe 2 = Occasionally have it, effect is severe 3 = Frequently have it, effect is not severe 4 = Frequently have it, effect is severe

- 1. ENT: Nasal congestion Stopped up nose Runny nose Sneezing Post-nasal drip Sinus infections Sinus pain Hay fever Ear ache Feeling fluid in ears
2. Pulmonary: Coughing Chest congestion Chest tightness Wheezing Difficulty breathing Heaviness in chest Shortness of breath on exertion
3. Throat: Sore throat Difficulty swallowing Canker sores
4. Eyes: Watery eyes Itching of eyes Redness of eyes Dark circles under the eyes
5. Digestive: Diarrhea Constipation Gas Belching Bloating Heartburn Indigestion Abdominal pain Coated tongue Hungry a lot Thirsty a lot Blood in stool
6. Psych/Neuro: Headaches Depression Anxiety Nervousness Panic Attacks Irritability Poor memory Poor concentration Mood Swings Can't Think Clearly Hyperactivity Insomnia Dizziness
7. Energy: Fatigue Wake up tired Unduly tired by the end of the day
8. Skin: Cold hands Cold feet Dry skin Acne Hives Skin rashes
9. Musculoskeletal: Muscle pain Joint pain Muscle cramps Neck pain/spasm Lower back pain/spasm Upper back pain/spasm
10. Cardiovascular: High blood pressure Low blood pressure Rapid heart beat Palpitations Irregular/skipped heart beat Chest pain
11. Urinary: Frequent urination Burning urination Awaken at night to urinate Urinate a lot
12. Female: Vaginal discharge Premenstrual symptoms Changes in menstrual cycle Vaginal dryness Hot flashes Night sweats Soreness of breast Lump, breast Blood/Discharge nipple
13. Are there some other symptoms or problems not listed above or the previous page that you would like to discuss: Yes No If yes, please explain:

14. Since your last visit, has there been any change in your family history, health of any family member, occupation, drug use, marital status, tobacco use, alcohol use, occupational exposures (exposure to tobacco smoke, fumes, dust, solvents, airborne particles, noise)?

Yes No If yes, explain:

15. Since your last visit, have you seen another physician? Yes No If yes, explain:

16. Basic Preventive Care: which of the following you did not have in the last one year: A. Flu vaccine; B. Cholesterol check ; C. Stool for occult blood (for colon cancer screen); D. Mammogram (Women); E.. Pap smear (Women) ; F. PSA (Men); Encircle that you did not have in the last one year. Check here if you are up-to-date on the above preventive care. Please Note: This is the recommended Preventive Care and we recommend it to you if you are over the age of 40.

Check here if you would like to discuss some of this preventive care with us

When did you have Pneumovax (pneumonia vaccination) (age50&over) H. Colonoscopy(age50& over)

17. All other symptoms negative (For office use)
18. Reviewed ROS done by patient today (initials) (For office use)