Patient History Update

What has happened since you were last here?

NAME_____ Date of Visit_____/_____/_____

Since your last visit, have you?	Yes	No	If yes, please specify
Had any illnesses?	___	___	_____
Seen any health care providers?	___	___	_____
Had any x-ray, lab, or other procedures?	___	___	_____
Had any change in your family medical history?	___	___	_____
Started, changed, or stopped any medications?	___	___	_____
New allergies/reactions to medications?	___	___	_____
Changes in smoking/drinking status?	___	___	_____

Describe how you feel compared to your last visit here? _____

_____

Please list all medications: (if not enough space, attach list)

Name of Medication	Dose and Frequency	Name of prescribing doctor.

Please list any medication allergies: _____

Please rate the following items using this scale: **0:** Problem not present today **1:** Much better **2:** Better **3**: Same **4:** Worse **5:** Much Worse **N:** New Problem

Pain:	Swelling:	Fatigue:	Skin Rash:
Difficulty Sleeping:	Mouth Ulcers:	Diarrhea/Constipation:	Mood:
Headache:	Eyes Dry:	Mouth Dryness:	Overall Assessment:

How long is your morning stiffness (min)? _____ **What is your worst pain?** _____. _ **Pain Level (0-10)?** _____

Exercise:

Type _____

Duration _____ min/day

Frequency _____ day/week

Sleep:

Duration _____ hours

Snore Yes / No

Restless Legs Yes / No

Mood:

Depression better / worse / same

Anxiety better / worse / same

Suicidal Thoughts Yes / No