Patient History Update

NAME____ Date of Visit_____/_____/_____

Do you have Medicare or Medicaid? ____ YES ___ NO

What is the most important item you want addressed at today's visit? ____

____

What joints or muscles hurt? ______________________________________ What joints are swollen? ______________________________________

How long is your morning stiffness (min)? _________ Where is your worst pain? ________________________________ Pain Level (0-10)? ______

Please list all medication allergies: ____

Please list all medications: (if not enough space, attach list). PLEASE DO NOT WRITE UNCHANGED

Name of Medication	Dose and Frequency	Name of prescribing doctor.

Is there any chance you are pregnant? ___ YES ___ NO **Are you having any side effects from your medications? ___ YES ___ NO**

Are you having any of the following since last visit? (circle) dry eyes dry mouth fatigue skin rash psoriasis diarrhea constipation reflux chest pain shortness of breath mouth ulcers headache depression anxiety suicidal thoughts blood in urine night sweats red eye recent infections weight gain weight loss dizziness seizures numbness/tingling color change of fingers in the cold

When was your last bone density test? __________ **When was your last eye exam?** __________ **When was your last dental exam?** __________

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