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PATIENT HEALTH HISTORY UPDATE

What has happened since you were last here?

Name _____ Date: _____

Since your last visit, have you:	Yes	No	If yes, please specify
Had any infections?	☐	☐	_____
Had any hospitalizations?	☐	☐	_____
Had any procedures or surgeries?	☐	☐	_____
Had any new allergies or reactions to medications?	☐	☐	_____

Please list any changes in your social situation: Work, relationships, residence, smoking, alcohol consumption

_____

_____

Please list any new allergies or reactions to medications

_____

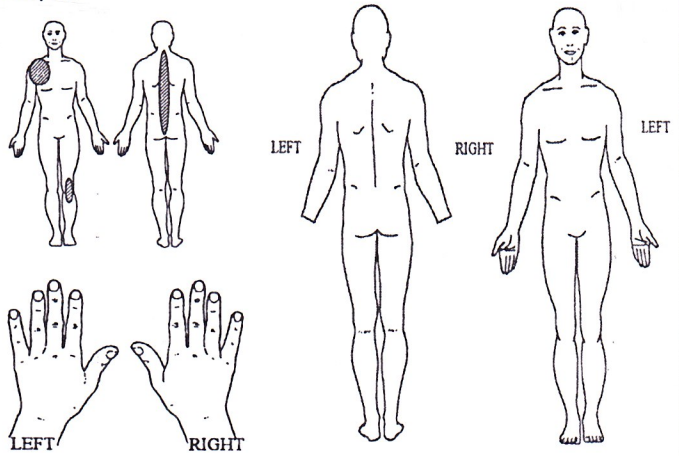
_____

Please list any medications which are new, changed, or stopped since your last visit

Name of Medication	New, Change, or Stop (For dose change, indicate current dosage)

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



How do you feel today as compared to your last visit here?

(Circle one) **Better** **Worse** **The Same**

Circle if you have had any of the following since your last visit.

Fever	Fatigue	Weight Loss	Dry Eyes	Dry Mouth	Oral Ulcers	Chest Pain	Cough	Shortness Of Breath
Diarrhea	Nausea	Vomiting	Skin Rash	Skin Ulcers	Difficulty Sleeping	Depression	Blood Clots	Numbness/ Tingling

How long does it take you to loosen up your joints in the morning?

_____

Patient Signature _____ Physician's Signature _____