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Specialists in:
Arthritis
Carpal Tunnel Syndrome
Fibromyalgia
Low Back Pain
Tendinitis
Bursitis
Connective Tissue Disease
Gout
Osteoporosis
Vasculitis

FOLLOW-UP PATIENT FORM

Name:________________________________ Visit Date:________________

Birth Date: ______________________ Primary Care Doctor: _______________________

Other doctors:

____

____

What is the main problem you are here for today?

____

____

Health Problems: Since last visit have you seen a physician for any new problems? Please give details.

____

____

____

Hospitalizations: Since last visit have you been hospitalized? Please give details.

____

Surgeries: Since last visit have you had any new surgeries? Please give details.

____

When was your last TB test? Never or ___________________ (Date and result)

Have you had a Bone Density Test? Yes / No When? _____________

Have you had any new immunizations (and date)?

____

____

Medication Allergies/ Intolerance: Since last visit have you developed any new drug allergies or intolerance? Please give details.

____

New Medications:

1. ____
2. ____
3. ____
4. ____
5. ____

Stopped Medications:

1. ____
2. ____
3. ____
4. ____
5. ____

Social History

Have you changed marital status? _________________________

Has your employment changed? __________________________

Do you exercise regularly? No Yes ____________________

Family History: Has there been any change to your family's medical history? Please give details.

____

Review of Systems (Please Circle if Present):

Fever
Weight loss
Rash
Fingers or toes turn colors in the cold
Headache
Focal muscle weakness
Vision disturbance
Dry eyes
Oral ulcers
Swollen lymph nodes
Chest pain
Ankle/leg swelling

Shortness of breath
Cough
Heartburn
Abdominal pain
Nausea
Vomiting
Diarrhea
Bloody stools
Black sticky stools
Burning with urination
Sleep disturbance