Joint Endeavors

Patient History Update (Please print neatly)

Name ______________________________ Today's Date___________________

Date of Birth____

Since your last visit, have you had any **new problems** or illnesses? Yes No
If yes, briefly describe:

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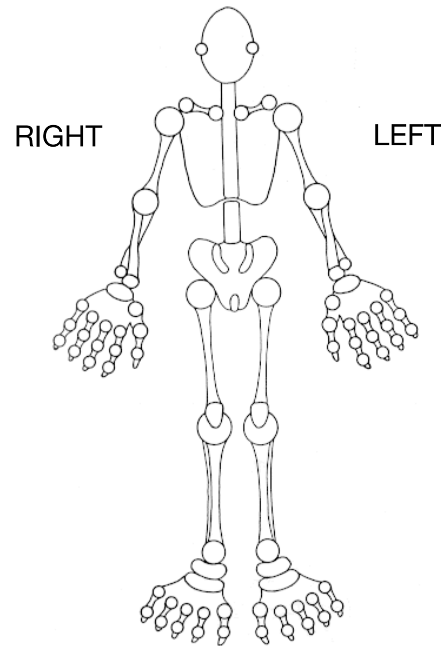
Place **X** on most symptomatic joint(s).



Seen any health care providers? Yes No
If yes, who did you see and why?

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Had any x-rays, labs or other tests? Yes No
If yes, what was done and where?

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Vaccines	**Date:**
Flu vaccine	________________________
Pneumovax 23	________________________
Prevnar 20	________________________
Shingrix	________________________
Covid-19	________________________

New diseases developed by family: parents, children, aunts, uncles, brother, sisters. Yes No	Changes in your social situation: work, relationships, smoking or alcohol consumption: Yes No	New allergy or reaction to medication: Yes No

OVER>>>>>

How do you feel today compared to your last visit here? (**Circle**)

Much improved Better Same Worse Much Worse

How long are you stiff in the morning? ________________minutes/hours

List any **changes of medications**. Include those that may have been stopped or added. Why?

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Please **Circle** any of these problems that significantly affect you:

Constitutional: Chills Fatigue Fever Weight gain Weight loss

Head: Headaches Scalp tenderness Hair loss

Eyes: Vision change Discharge Excessive Tearing Eye Pain Glaucoma
Infection Red eyes Dry Eyes Light sensitive

Nose: Discharge Frequent Colds Hay Fever Infections Nosebleeds
Sinus Infections Nasal ulcers Dry

Mouth: Bleeding gums Hoarseness Postnasal Drip Mouth ulcers Jaw pain
Swollen salivary glands Dry Mouth

Ears: Discharge Dizziness Hearing loss Infections Pain Ringing in ears

Throat/Neck: Frequent sore throats Swollen glands Tenderness

Respiratory: Cough Wheezing Bronchitis Short of air Sputum Coughing blood

Cardiovascular: Chest Pain Palpitations Cold hands/feet Heart murmur
High blood pressure Heart attack Swollen feet Leg ulcers Blue fingers

Gastrointestinal: Abdominal Pain Constipation Diarrhea Heartburn Jaundice
Blood in stool Tarry Stools Change in stool color Poor appetite Hemorrhoids
Infections Nausea Swallowing difficulty Vomiting Vomiting Blood

Musculoskeletal: Joint pain Gout Back Problems Joint stiffness Muscle cramps
Muscle Stiffness Restricted Motion Leg cramps

Psychiatric: Anxiety Depression Disorientation Excessive Stress Hallucinations
Mood changes Insomnia Panic

Skin: Eczema Itching Dryness Hives Change in mole
Nail change Rash Sun rash Psoriasis

Neurological: Blackouts Burning Memory loss Numbness Strokes
Tingling Tremor Unsteady walking Weakness

Endocrine: Cold Intolerance Heat Intolerance Thirsty Sweats Hair thin/thick

Hematologic/Lymph: Anemia Bleeding Easily Blood clots Easy bruising
Swollen glands Low white count Low platelets

Allergic/Immunologic: Hives Itchy Eyes Recurrent infections Sneezing Runny nose

Genitourinary: Awakening to urinate Blood in urine Burning Difficulty urinating
Frequent urination Loss of bladder control Infections Stones

Physician's initial ___________