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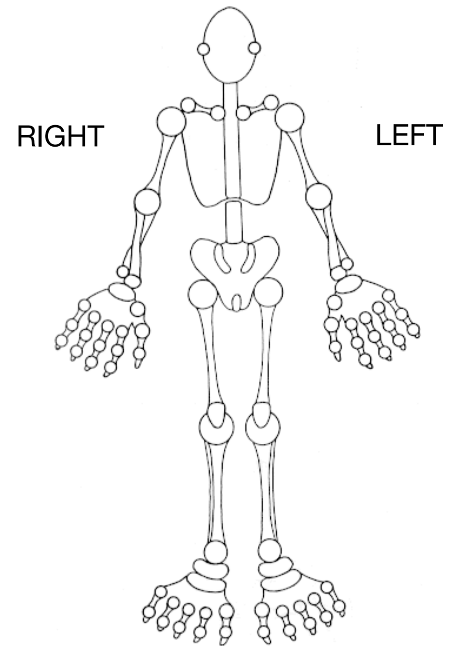
Place **X** on most symptomatic joint(s).



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	____________________
Prevnar 13	____________________
Shingrix	____________________
Zostavax	____________________

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: Dizziness   Headaches   Sweats   Scalp tenderness   Hair loss

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

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

Mouth: Bleeding gums   Change in dentition   Hoarseness   Postnasal Drip   Tongue Burning
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   Tonsils enlarged

Respiratory: Cough   Wheezing   Bronchitis   Short of air   Sputum   Coughing blood

Cardiovascular: Chest Pain   Palpitations   Varicose veins   Cold hands/feet   Heart murmur
High blood pressure   Heart attack   Leg cramps   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   Rectal pain   Swallowing difficulty   Vomiting   Vomiting Blood

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

Psychiatric: Anxiety   Depression   Behavioral Change   Disorientation   Disturbing Thoughts
Excessive Stress   Hallucinations   Mood changes   Insomnia   Panic

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

Neurological: Blackouts   Burning   Dizziness   Memory loss   Numbness   Paralysis
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
Radiation   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

Patient's Name________________________________ Date________________ Physician's initial _________