LOUISIANA ARTHRITIS & RHEUMATOLOGY
Get the personal attention you deserve.

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# Patient History Update

What has happened since you were last here?

Name:_____ Age:_____

| Since your last visit, have you? | Yes | No | If yes, please specify |
|---|---|---|---|
| Had any illnesses? | ❑ | ❑ | _____ |
| Seen any health care providers? | ❑ | ❑ | _____ |
| Had any x-ray, lab or other procedures? | ❑ | ❑ | _____ |
| Had any change in your family medical history? | ❑ | ❑ | _____ |
| Had any change in your social history? | ❑ | ❑ | _____ |
| Had any new allergies or reactions to medications? | ❑ | ❑ | _____ |
| Started, changed or stopped any medications? | ❑ | ❑ | _____ |

| **New diseases or illnesses developed by relatives (parents, children, aunts, uncles, brothers, sisters)** | **Changes in your social situation: Work, relationships, residence, smoking, alcohol consumption** | **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) | **Name of prescribing doctor**. If you made the change, put Self | **Why was the medication changed or stopped?** No longer needed? No longer effective or not ever effective? Side effects (please specify)? |
|---|---|---|---|
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How Do You Feel Today as Compared to Your Last Visit Here?

Please rate the following items using this scale:

0=Problem not present today 1=Much better 2=Better 3=Same 4=Worse 5=Much Worse N=New Problem

| | | | | | |
|---|---|---|---|---|---|
| Pain: | Swelling: | Fatiuge: | Ringing in Ears: | Stomach Upset: | Skin Rash: |
| Bruising: | Difficulty Sleeping: | Cough: | Eyes Red: | Chest Pain: | Fever: |
| Oral Ulcers: | Diarrhea: | Skin Ulcers: | Swollen Glands: | Headache: | Shortness of Breath: |
| Eyes Dry | Heart Palpitations: | Weight Loss: | **Overall Assessment:** | | |

How long is your morning stiffness (minutes)?_____ What is your worst joint?_____

Patient's Name:_____ Date_____ Physician Initials_____