Arthritis Consultants, P.A. Return Visit HPI

NAME: _____ DOB: _____ DATE: _____

Please write your answers and circle responses as indicated below:

SINCE YOUR LAST VISIT:

Any new medications, changes in your meds, or reactions to any meds?
YES NO If "YES" please explain:_____
Have you had blood/urine tests taken ?
YES NO If "YES" where? QUEST METROPLEX CPL OTHER: _____
Have x-rays or other scans been performed?
YES NO If "YES" where? METROPLEX DARNALL OTHER: _____
Have you seen other doctors?
YES NO If "YES" Who and what for?_____
Has family history changed? (new diagnosis of cancer, diabetes, other condition since last visit)
YES NO If "YES" what changed? _____
Have you changed jobs, moved, quit or started smoking, drinking alcohol since last visit?
YES NO If "YES please explain: _____

REASON FOR VISIT:

PAIN SEVERITY TODAY (0 =NO PAIN and 10= WORST)

Level of pain- ***0 1 2 3 4 5 6 7 8 9 10***
Is your pain- ***BETTER WORSE SAME since last visit?***

MAIN PAIN/PROBLEM: (to evaluate at this visit) HEAD NECK CHEST SHOULDER ELBOW WRIST FINGERS LOW BACK HIP KNEE ANKLE FEET REVIEW TESTS OTHER: _____

Is pain: ACHING BURNING SHARP TINGLING THROBBING CRAMPING
Is pain: CONSTANT INTERMITTENT
Has pain been going on for: DAYS WEEKS MONTHS YEARS
Does pain radiate to: ARMS HANDS LEGS FEET OTHER: _____
What makes the pain better: HEAT COLD ACTIVITY REST OTHER: _____
What makes the pain worse: HEAT COLD ACTIVITY OTHER: _____

****** *IMPORTANT***PLEASE GO TO NEXT PAGE AND COMPLETE ************

Arthritis Consultants, P.A. Return Visit ROS

NAME: _____ DOB: _____ DATE: _____

Systems	Please circle any that applies to you:
Constitutional Symptoms	1. Fever 2. Weight Change (gained_____ lost_____) 3. Fatigue
Eyes	4. Blurring 5. Double Vision 6. Dry Eyes 7. Recurrent Redness 8. Light Sensitivity
Ears, Nose, Throat & Mouth	9. Deafness 10. Dizziness 11. Sinus Congestion 12. Dry Mouth 13. Mouth Ulcers
Cardiovascular	14. Chest Pain 15.Palpitations 16. Irregular Beats 17. High Blood Pressure
Respiratory	18. Shortness of Breath 19. Wheezing Cough 20. Blood in sputum 21. Painful Breathing
GI	22. Appetite change 23. Difficulty Swallowing 24. Abdominal Pain 25. Diarrhea 26. Constipation 27. Blood in Stool 28. Hemorrhoids
GU	29. Loss of Bladder Control 30. Difficulty Urinating 31. Pain Urinating 32. Blood in Urine 33. Kidney Stones
Musculoskeletal	34. Fractures 35. Sprains 36. Painful Joints 37. Swollen Joints 38. Joint Stiffness
Skin	39. Rashes 40. Color Changes 41. Skin Ulcers 42. Knots/ Skin Nodules
Neuro	43. Weakness 44. Numbness 45.Tingling 46. Seizures 47. Memory 48. Coordination Problem
Psychological	49. Depression 50. Mood Swings 51. Sleep Disturbances
Endocrine	52. Excessive Hunger or Thirst or Urination 53. Change in Hair Growth (loss or gain)
Hematologic/Lymph	54. Anemia 55. Bleeding Tendency 56. Lymph Node Pain/Enlargement
Allergic/Immune	57. Hives 58. Eczema 59. Itching

☐ **All unmarked systems are unremarkable.**

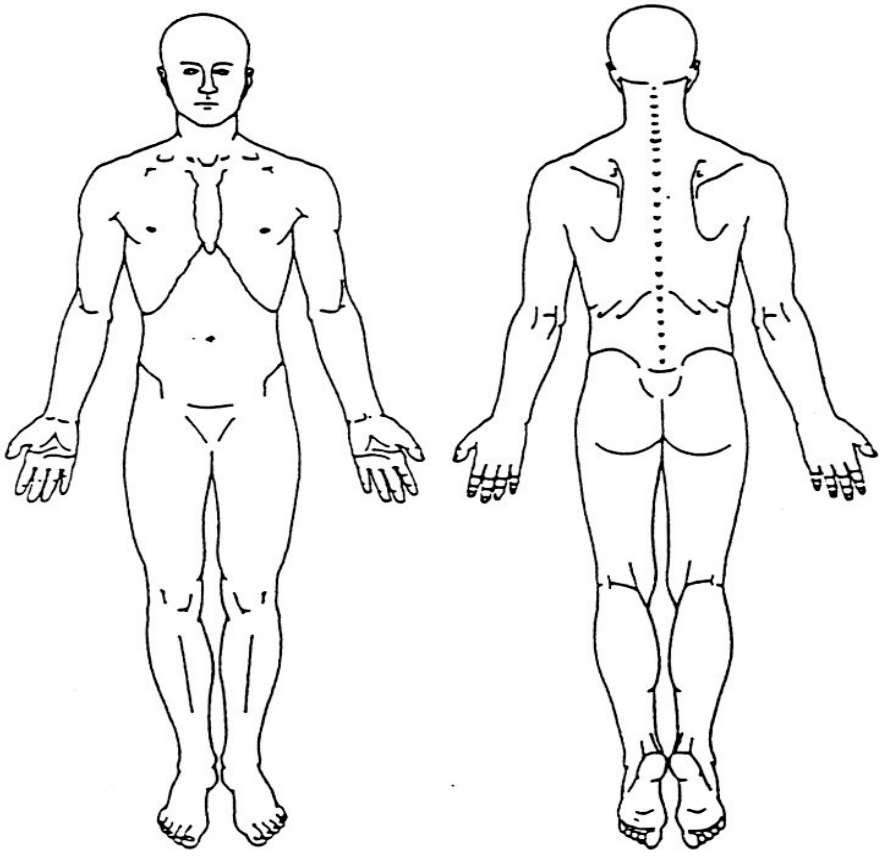
STAFF COMMENTS ONLY:

Arthritis Consultants, P.A. Return Visit

NAME: _____ DOB: _____ DATE: _____

Pain Diagram

Please put an X in the most severe, painful area, all aching with OOOO and sharp/burning with//////:



JJ/jj rev 3/15/09