Patient Name: _____ **Date of Visit:** _____

Reason for Today's Visit: _____

Do you need any refills today? Yes/No If yes, please list: _____

_____

_____

_____

Please list any medical/surgical procedures/changes since your last visit:

_____

_____

_____

1. How much pain have you had because of your condition <u>OVER THE PAST WEEK</u>?
(Place a mark on the line below to indicate how severe your pain has been)
NO PAIN |——————————————————————| EXTREME PAIN

2. When you get up in the morning, do you feel stiff? Yes No
If yes, how many minutes or hours until you are as lumber as the previous day? _____

3. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?
(Place a mark on the line below to indicate how severe your fatigue has been)
NO PROBLEM |——————————————————————| MAJOR PROBLEM

4. How do you feel TODAY compared to 2 WEEKS AGO? (Please choose only one)
□ Much Better □ Better □ The Same □ Worse □ Much worse today then 2 weeks ago

5. Considering all the ways in which illness and health conditions may affect you at this time, please mark below to show
VERY WELL |——————————————————————| VERY POORLY

6. Please check if you have experienced any of the following <u>OVER THE LAST MONTH:</u>

_____ Fever	_____ Lump in throat	_____ Paralysis arms/legs
_____ Weight gain/loss (circle)	_____ Cough	_____ Numbness/tingling arms/legs
_____ Feeling Sickly	_____ Shortness of breath	_____ Fainting spells
_____ Headaches	_____ Wheezing	_____ Swelling hands/ankles
_____ Unusual fatigue	_____ Pain in the chest	_____ Swelling other joints
_____ Swollen glands	_____ Heart pounding	_____ Joint pain
_____ Loss of appetite	_____ Trouble swallowing	_____ Back pain
_____ skin rash or hives	_____ Heart/stomach gas	_____ Neck pain
_____ Unusual bruising/bleeding	_____ Stomach pain/cramps	_____ Use of drugs not sold in stores
_____ Other skin problems	_____ Nausea	_____ Smoking Cigarettes
_____ Loss of hair	_____ Vomiting	_____ More than 2 alcholic drinks/day
_____ Dry eyes	_____ Constipation	_____ Depression
_____ Other eye problems	_____ Diarrhea	_____ Anxiety
_____ Problems with hearing	_____ Dark/bloody stools	_____ Problems thinking
_____ Ringing in the ears	_____ Problems with urination	_____ Problems w/memory
_____ Stuffy nose	_____ Gyn/female problems	_____ Problems sleeping
_____ Sores in the mouth	_____ Dizziness	_____ Sexual problems
_____ Dry mouth	_____ Loss of balance	_____ Burning in sex organs
_____ Problems with smell/taste	_____ Muscle pain/aches/weakness	_____ Problems with social activities

□ Medication reviewed with patient and Y/N from last appointment.

Patient: ______________________________

Allergies: ____

Start Date	D/C date	Medication	Strength	Dosage Directions