| 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:    Please list any medical/surgical procedures/changes since your last visit:    Please list any medical/surgical procedures/changes since your last visit:    Please mark on the line below to indicate how severe your pain has been   | Patient Name:  | Date of   | f Visit:                        |
|--|--|---|---------------------------------|
| Please list any medical/surgical procedures/changes since your last visit:    1. How much pain have you had because of your condition OVER THE PAST WEEK?   1. Power many minutes or hours until you are as lumber as the previous day?   2. When you get up in the morning, do you feel stiff? Yes No   EXTREME PAIN  | Reason for Today's Visit:  |   |                                 |
| Learn   Last mount   Last mou | Do you need any refills today? Yes/No  | o If yes, please list:  |                                 |
| 1. How much pain have you had because of your condition OVER THE PAST WEEK?  (Place a mark on the line below to indicate how severe your pain has been)  NO 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  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  6. Please check if you have experienced any of the following OVER THE LAST MONTH:  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 than plain in the chest Swelling hands/ankles  Unusual fatigue Pain in the chest Swelling Back pain Skin rash or hives Heart/stomach gas Neck 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 Smoking Cigarettes  Other skin problems Nausea Smoking Cigarettes  Other skin problems Diarnhea Anxiety  Problems with hearing Dark/bloody stools Problems thinking  Problems with hearing Dark/bloody stools Problems wemony  Stuffy nose Gyn/female problems  Dry mouth Loss of balance Burning in sex organs  |  |   |                                 |
| 1. How much pain have you had because of your condition OVER THE PAST WEEK?  Place a mark on the line below to indicate how severe your pain has been)  NO PAIN  2. When you get up in the morning, do you feel stiff? Yes No lifyes, 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  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  6. Please check if you have experienced any of the following OVER THE LAST MONTH:  Fever Lump in throat Paralysis arms/legs  Weight gain/loss (circle) Cough Numbness/tingling arms/legs  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  Skin rash or hives Heart/stomach gas Neck pain  Skin rash or hives Heart/stomach gas Smoking Cigarettes  Unusual bruising/bleeding Stomach pain/cramps Use of drugs not sold in stores  Trouble swallowing More than 2 alcholic drinks/day  Dry eyes Constipation Depression  Other eye problems Diarrhea Anxiety  Problems with hearing Dark/bloody stools Problems w/memory  Stuffy nose Gyn/female problems  Dry mouth Loss of balance Barning in sex organs  |  |   |                                 |
| EXTREME PAIN   | Please list any medical/surgical procedures/ch   | nanges since your last visit:   |                                 |
| 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?   Chace a mark on the line below to indicate how severe your fatigue has been     NO PROBLEM  | (Place a mark on the line below to indicate ho   | ow severe your pain has been)   | REME PAIN                       |
| Place a mark on the line below to indicate how severe your fatigue has been   NO PROBLEM   |  |   |                                 |
| Much Better   Better   The Same   Worse   Much worse today then 2 weeks ago    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WELL   VERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WELL   VERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WELL   VERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WELL   VERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY WERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY POORLY    Seconsidering all the ways in which illness and health conditions may affect you at this time, please mark below to show VERY POORLY    Paralysis arms/legs   | (Place a mark on the line below to indicate ho   | ow severe your fatigue has been)  |                                 |
| 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 Dry mouth Loss of balance Burning in sex organs   | <ul><li>☐ Much Better ☐ Better ☐ The Same ☐ W</li><li>5. Considering all the ways in which illness a</li></ul> | Vorse   Much worse today then 2 weeks ago and health conditions may affect you at this to | ime, please mark below to show  |
| Weight gain/loss (circle)CoughNumbness/tingling arms/legsFeeling SicklyShortness of breathFainting spellsHeadachesWheezingSwelling hands/anklesUnusual fatiguePain in the chestSwelling other jointsSwollen glandsHeart poundingJoint painLoss of appetiteTrouble swallowingBack painskin rash or hivesHeart/stomach gasNeck painUnusual bruising/bleedingStomach pain/crampsUse of drugs not sold in storesOther skin problemsNauseaSmoking CigarettesLoss of hairVomitingMore than 2 alcholic drinks/dayDry eyesConstipationDepressionOther eye problemsDiarrheaAnxietyProblems with hearingDark/bloody stoolsProblems thinkingRinging in the earsProblems with urinationProblems w/memoryStuffy noseGyn/female problemsProblems sleepingSores in the mouthDizzinessSexual problemsDry mouthLoss of balanceBurning in sex organs   | 6. Please check if you have experienced any o  | of the following OVER THE LAST MONTH:   |                                 |
| Feeling Sickly  Headaches  Wheezing  Wheezing  Swelling hands/ankles  Unusual fatigue  Pain in the chest  Swelling other joints  Swollen glands  Heart pounding  Loss of appetite  Trouble swallowing  skin rash or hives  Unusual bruising/bleeding  Other skin problems  Loss of hair  Vomiting  Dry eyes  Constipation  Other eye problems  Problems with hearing  Ringing in the ears  Problems with mouth  Shortness of breath  Fainting spells  Swelling hands/ankles  Swelling hands/ankles  Swelling other joints  Joint pain  Back pain  Neck pain  Use of drugs not sold in stores  Smoking Cigarettes  More than 2 alcholic drinks/day  Depression  Other eye problems  Diarrhea  Anxiety  Problems with hearing  Ringing in the ears  Problems with urination  Problems w/memory  Stuffy nose  Gyn/female problems  Problems  Sexual problems  Dry mouth  Loss of balance  Burning in sex organs   | Fever  | Lump in throat  | Paralysis arms/legs             |
| 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  Dry mouth Loss of balance Burning in sex organs  | Weight gain/loss (circle)  | Cough   | Numbness/tingling arms/legs     |
| Unusual fatiguePain in the chestSwelling other jointsSwollen glandsHeart poundingJoint painLoss of appetiteTrouble swallowingBack painskin rash or hivesHeart/stomach gasNeck painUnusual bruising/bleedingStomach pain/crampsUse of drugs not sold in storesOther skin problemsNauseaSmoking CigarettesLoss of hairVomitingMore than 2 alcholic drinks/dayDry eyesConstipationDepressionOther eye problemsDiarrheaAnxietyProblems with hearingDark/bloody stoolsProblems thinkingRinging in the earsProblems with urinationProblems w/memoryStuffy noseGyn/female problemsProblems sleepingSores in the mouthDizzinessSexual problemsDry mouthLoss of balanceBurning in sex organs  | Feeling Sickly   | Shortness of breath   | Fainting spells                 |
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| Loss of hairVomitingMore than 2 alcholic drinks/dayDry eyesConstipationDepressionOther eye problemsDiarrheaAnxietyProblems with hearingDark/bloody stoolsProblems thinkingRinging in the earsProblems with urinationProblems w/memoryStuffy noseGyn/female problemsProblems sleepingSores in the mouthDizzinessSexual problemsDry mouthLoss of balanceBurning in sex organs  |  | <del></del>   |                                 |
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| Problems with smell/taste Muscle nain/aches/weakness Problems with social activities   | Problems with smell/taste  | Muscle pain/aches/weakness  | Problems with social activities |

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

| Patient:   |  |  |
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| Allergies: |  |  |
| ,c. 8.co.  |  |  |

| Start Date | D/C date | Medication | Strength | Dosage Directions |
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Agnes Solon, MD Medication Log