ARTHRITIS AND RHEUMATOLOGY CENTER OF MI
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)?

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:	Fatigue:	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 _____