

**ARTHRITIS/RHEUMATOLOGY CLINIC OF NORTHERN CO, LLC
Followup Patient Questionnaire**

NAME: _____ **DATE:** _____ **DOB:** _____

What is the main reason for your visit today? Routine followup. New problem.

If this is a new problem, please describe _____

**IF YOU HAVE REVIEWED THE QUESTIONS BELOW AND THERE ARE NO CHANGES
SINCE YOUR LAST VISIT, PLEASE CHECK HERE**

UPDATE ON PAST MEDICAL HISTORY: (New problems or changes since last office visit)

New medications, or medication allergies.	<input type="checkbox"/> No. <input type="checkbox"/> Yes (please list/describe)
New medical problems, hospitalizations, surgeries.	<input type="checkbox"/> No. <input type="checkbox"/> Yes (please describe)
Change in social situation.	<input type="checkbox"/> No. <input type="checkbox"/> Yes (please describe)
Change in smoking status or alcohol consumption.	<input type="checkbox"/> No. <input type="checkbox"/> Yes (please describe)
New health problems in close family members.	<input type="checkbox"/> No. <input type="checkbox"/> (please describe)

REVIEW OF SYSTEMS: (please check if you have had any of these symptoms since your last appointment).

- | | |
|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Unintended weight loss | <input type="checkbox"/> Black/tarry stools |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Trouble urinating |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> New or increased numbness in extremities |
| <input type="checkbox"/> Visual problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Abnormal bruising/bleeding |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Morning stiffness: how long? |
| <input type="checkbox"/> Mouth sores | |
| <input type="checkbox"/> Hoarseness | |
| <input type="checkbox"/> Cough | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Stomach pain | |

Reviewed by physician: _____ **Date:** _____

