

**AMERICAN COLLEGE OF RHEUMATOLOGY  
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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seen any health care providers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any x-ray, lab or other procedures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any change in your family medical history?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any change in your social history?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any new allergies or reactions to medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Started, changed or stopped any medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 \_\_\_\_\_