RHEUMATOLOGY ASSOCIATES, P.C.
195 Eastern Boulevard, Suite 201 Glastonbury, CT 06033
860 246-4260 fax: 860 430-9770

MEDICAL HISTORY UPDATE

Name:_____ Date of Birth:_____

Briefly describe what brings you back: _____

_____

Please tell us about any changes to your health since your last visit:

New Medical Problems: _____

_____

New surgeries:_____

New Medication Allergies:_____

Change in family medical history: _____

Change in personal history: _____

Change in medications: ☐ Yes ☐ No If yes, provide list on back

SYMPTOMS REVIEW

☐ Recent weight gain; how much_____
☐ Recent weight loss; how much _____
☐ Fatigue
☐ Fever
☐ Eye pain
☐ Eye redness
☐ Vision change
☐ Dry eyes
☐ Sores in nose
☐ Sores in mouth
☐ Easy bruising
☐ Dry mouth
☐ Difficulty in swallowing
☐ Jaw cramping
☐ Cough
☐ Chest pain
☐ swollen legs or feet
☐ Heartburn
☐ Stomach pain
☐ Diarrhea
☐ Constipation
☐ Painful urination
☐ Rash
☐ Hair loss
☐ Color changes of fingers or toes in the cold
☐ Headache
☐ Numbness or tingling
☐ Muscle weakness
☐ Depression
☐ Anxiety
☐ Sleep difficulties
☐ Shortness of breath

MEDICATION LIST

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____