Office Use Only:
Wt _____ Ht _____ BP _____
P _____ R _____

Beals Institute

Patient History Update Today's Date_____

Name _____ **Date of Birth** _____

Please list your 2 most important concerns for today's visit:

1) _____

2) _____

Refills Needed: _____

_____

_____

Since your last visit, have you?	**Yes**	**No**	**If yes, please specify**
Had any injuries or illnesses?	☐	☐	_____
Seen any other health care providers?	☐	☐	_____
Had any X-rays, Labs, or other procedures?	☐	☐	_____
Had any changes in your family medical history?	☐	☐	_____
Had any changes in your social situation? (Work, relationship, housing, alcohol, smoking)	☐	☐	_____
Had any new allergies or reactions to medications?	☐	☐	_____

How long is your morning stiffness (minutes)? _____ What is your worst joint? _____

Check ***YES*** or ***NO*** to the following in regards for your health within the ***LAST WEEK***:

Yes	No		Yes	No		Yes	No	
☐	☐	Fatigue	☐	☐	Cough	☐	☐	Joint Pain
☐	☐	Weight Gain	☐	☐	Wheezing	☐	☐	Joint Redness
☐	☐	Weight Loss	☐	☐	Chest Pain	☐	☐	Joint Stiffness
☐	☐	Sleeping Difficulty	☐	☐	Hypertension	☐	☐	Joint Swelling
☐	☐	Hair Loss	☐	☐	Shortness of Breath	☐	☐	Muscle Pain
☐	☐	Rash	☐	☐	Swelling of Extremities	☐	☐	Muscle Weakness
☐	☐	Headache	☐	☐	Cold Extremities	☐	☐	Dizziness
☐	☐	Visual Disturbances	☐	☐	Abdominal Pain	☐	☐	Numbness
☐	☐	Decreased Hearing	☐	☐	Constipation	☐	☐	Memory Loss
☐	☐	Ringing in the Ears	☐	☐	Diarrhea	☐	☐	Anxiety
☐	☐	Seasonal Allergies	☐	☐	Heartburn	☐	☐	Depression
☐	☐	Oral Ulcers	☐	☐	Nausea	☐	☐	Appetite Changes
☐	☐	Neck Pain	☐	☐	Vomiting	☐	☐	Thyroid Problems
☐	☐	Neck Stiffness	☐	☐	Urinary Frequency	☐	☐	Easy Bruising