

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

- | | | |
|---|--|---|
| <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Weight Gain <input type="checkbox"/> <input type="checkbox"/> Weight Loss <input type="checkbox"/> <input type="checkbox"/> Sleeping Difficulty <input type="checkbox"/> <input type="checkbox"/> Hair Loss <input type="checkbox"/> <input type="checkbox"/> Rash <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> <input type="checkbox"/> Oral Ulcers <input type="checkbox"/> <input type="checkbox"/> Neck Pain <input type="checkbox"/> <input type="checkbox"/> Neck Stiffness | <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Chest Pain <input type="checkbox"/> <input type="checkbox"/> Hypertension <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> <input type="checkbox"/> Swelling of Extremities <input type="checkbox"/> <input type="checkbox"/> Cold Extremities <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Heartburn <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> Urinary Frequency | <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Joint Pain <input type="checkbox"/> <input type="checkbox"/> Joint Redness <input type="checkbox"/> <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> <input type="checkbox"/> Muscle Pain <input type="checkbox"/> <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> Memory Loss <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Appetite Changes <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> Easy Bruising |
|---|--|---|