BERGEN

GASTROENTEROLOGY • MEDICAL ASSOCIATES

committed to the highest level of patient care

Rheumatology Follow Up Patient Form

Date:____________________________

First Name:__________________ Last Name: __________________ Date of Birth:______________________

Acct #:________________________________

Since your last visit have you:	Yes	No	If yes, please specify:
Had any illness or new diagnosis?	☐	☐	
Been seen by any other doctors?	☐	☐	
Had any x-rays, labs, and/or other procedures?	☐	☐	
Any new allergies or reactions to medicines?	☐	☐	
Any relatives with new diagnosis of major illnesses (parents, grandparents, children, siblings etc.)?	☐	☐	
Any changes in your social situation (work, residence, relationships, smoking,alcohol use, etc.)?	☐	☐	
Had any medication started, stopped, or dosage changed?	☐	☐	Name of medicine:________ New/Stopped/Dose changed:________ Person who made this change:________ Reason this change was made:________

How do you feel today compared with your last visit here? ______________________________

Please rate the following items using this scale:

N = new problem 0 = problem not present today 1 = much better 2 = better 3 = same 4 = worse 5 = much worse

Pain		Fever		Anxiety	
Poor Sleep		Eyes dry		Chest pain	
Blood in stool		Hair loss		Muscle weakness	
Joint swelling		Weight loss		Skin rash or ulcers	
Headache		Cough		Heart palpitations	
Stomach upset		Swollen glands		Numb in limb(s)	
Fatigue		Depression		Bruising or bleeding	
Eyes red		Shortness of breath		Diarrhea	
Change in urine		Muscle ache		Overall assessment	

How long are your joints stiff in the morning (minutes)?____________________________

Which part of your body feels the worst?__________________________________

SAVE FORM SUBMIT FORM