Since Dr Dore Last Saw You ... Have you

☐Y ☐N **Had any illnesses? Broken any bones?**

☐Y ☐N **Seen any doctors, dentists?**

☐Y ☐N **Had any ☐ x-ray, ☐ lab or ☐ medical / dental procedure?**

☐Y ☐N **Had a change in your family medical history?** **(New diseases or illnesses** developed by relatives, parents, children, aunts, uncles, brothers, sisters)

☐Y ☐N **Had a change in your social history?**
(Work, relationships, residence, smoking, alcohol consumption)

☐Y ☐N **Had any new allergies or reactions to medications?**

☐Y ☐N **Started, changed dose or stopped any medication?** ☐Y ☐N **Changed insurance?**

Medication that is: **NEW, CHANGED DOSE OR STOPPED:** (Since last visit)	N = New C = Changed S = Stopped	What is the CURRENT DOSE?	Who prescribed, changed or stopped? If you made the change, put Self	Reason for new medication? Reason for changing dose or stopping?

☐Y ☐N **Are you exercising?** ☐ Walking ☐ Stretching ☐ Other _____

How Do You Feel – Today ?

Below are common **problems** I need you to tell me about ...

First: Put **N** for a **New problem**

Next: For a **problem that was *present last visit*** – **tell me how it is today.**
***(Rate it** as follows.)*

1 =Much better **2** =Better **3** =Same **4** =Worse **5** =Much Worse

Pain	Swelling	Fatigue:

*Finally: If a problem isn't present today and wasn't present last visit, just put a **0** in the box*

Fever	Bruising	Skin rash	Skin Ulcers	Ringing in ears	Eyes red	Eyes dry	Oral Ulcers	Swollen glands

Chest pain	Heart palpitations	Shortness of breath	Cough	GI Upset	Diarrhea	Headache	Difficulty sleeping	Weight loss

How long is your **Morning Stiffness**? _____ minutes

What is your **Worst Joint?** _____

What is your **Overall Assessment** compared to last visit? ___ 1 =Much better 2 =Better 3 =Same 4 =Worse 5 =Much Worse

☐Y ☐N Are there any **other** problems you want to mention: _____

Update Name: _____ Age: ____/ _____, 2013 Reviewed by: _____ **Dr DORE**

EMAIL: _____ **[] none**