**Dr. Anthony Krajcer**
**Patient History Update**

**Name: _____ Age: _____**

| Since your last visit, have you... | Yes | No | If yes, please specify |
|---|---|---|---|
| -Had any illnesses? | ☐ | ☐ | _____ |
| -Seen any healthcare providers? | ☐ | ☐ | _____ |
| -Had any x-ray, lab, procedures? | ☐ | ☐ | _____ |
| -Had any change in your family medical history? | ☐ | ☐ | _____ |
| -Had any new allergies or reaction to medications? | ☐ | ☐ | _____ |
| -Had any changes to your social life you would like to note? | ☐ | ☐ | _____ |

**Please list any medications which are new, changed, or stopped since your last visit:**

| Name of medication | New, change, or stop (for dose change, put current dose) | Name of prescribing doctor. If you made the change, put Self. | Why was this medication changed or stopped? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

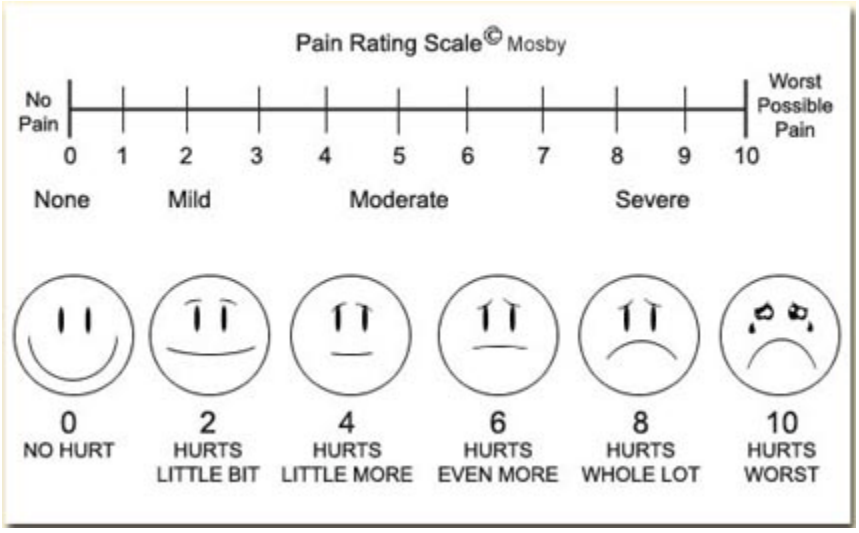
**How do you feel today as compared to your last visit?**
**Please rate the following using this scale:**
**0 – Issue not present 1 – Much better 2 – Better 3 – Same 4 – Worse 5 – Much worse N – New issue**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Pain:** | **Swelling:** | **Fatigue:** | **Ringing in ears:** | **Upset stomach:** | **Skin rash:** | **Bruising:** |
| **Difficulty sleeping:** | **Cough:** | **Red eyes:** | **Chest pain:** | **Fever:** | **Oral ulcers:** | **Diarrhea:** |
| **Skin ulcers:** | **Swollen glands:** | **Headache:** | **Shortness of breath:** | **Dry eyes:** | **Weight loss:** | **Heart palpitations:** |

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

**PLEASE TURN OVER AND COMPLETE BACK SIDE AT YOUR CONVENIENCE.**

**Please circle below how your pain is affecting you today.**




Mark these drawings according to where you hurt. Please use the scale below to indicate which sensations you are feeling.

/ / / Stabbing

XXX Burning

+ + + Aching

= = = Numbness

0 0 0 Pins & Needles