Patient Follow-Up Questionnaire (Please CIRCLE your Answers)

1. Name: 2. Date:

3. Height: 4. Weight: 5. Pharmacy:

5. How do you feel compared to your last visit? Better Worse Same

6. Since your last visit, have you….

    a. Seen another physician?

    b. Visited the ER?

    c. Had surgery?

    d. Been in the hospital?

    e. Had X-rays? When: Where:

    f. Had lab work? When: Where:

    g. Had Physical therapy?

7. Please list any new medications since your last visit:

8. Have you experienced any medication side effects?

9. Please rate your overall pain today: 0 2 3 4 5 6 7 8 9 10

(none) (severe)

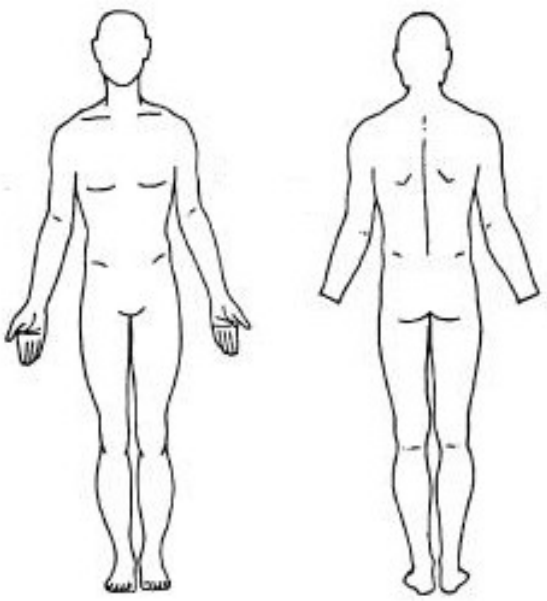
10. Does your pain cause you difficulty while performing your:

A. Job?

B. Recreational interests?

C. Self-care (getting dressed, bathing, personal hygiene, etc.)?

11. Please circle the location of your pain:



12. How long does your AM stiffness last?

No stiffness 15 minutes or less 30 minutes 45 minutes 60 minutes 90 minutes

2 hours 3 hours 4 hours 5 or more hours

13. Are you experiencing any of the following TODAY:

- Fatigue
- Fever/ Chills/ Sweats
- Weight loss/ Weight gain

- Sleep Disturbance
- Inflamed Eyes
- Dry Eyes/ Mouth
- Change in your Vision
- Hearing Loss/ Ringing
- Sinus Congestion/ Nosebleed
- Mouth Sores
- Shortness of Breath
- Chest Pain while Breathing
- Cough/ Wheezing
- Exertional Chest Pain
- Palpitations
- Fainting/ Dizziness
- Color Changes in your Fingers/ Toes
- Abdominal Pain
- Nausea/ Vomiting
- Diarrhea
- Heartburn
- Trouble Swallowing
- Blood in Stool
- Pain during Urination
- Rash/ Itching/ Hives

- Headache
- Numbness/ Tingling
- Seizures
- Weakness
- Shaking
- Memory Loss
- Swollen Glands
- Bruising
- Bleeding
- Heat/ Cold Intolerance
- Excessive Thirst

If none, please check box ☐