RETURN PATIENT FORM

PATIENT NAME:_____**DATE:**_____

DOB: _____**PRIMARY CARE PHYSICIAN:** _____

PHARMACY: (INCLUDE NAME, ADDRESS AND PHONE NUMBER)
LOCAL: _____

MAIL ORDER/SPECIALTY: _____

PATIENT ASSESSMENT

Over the last week, were you able to:	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
Dress yourself, including tying shoelaces and doing buttons?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of bed?	❑ 0	❑ 1	❑ 2	❑ 3
Lift a full cup or glass to your mouth?	❑ 0	❑ 1	❑ 2	❑ 3
Walk outdoors on flat ground?	❑ 0	❑ 1	❑ 2	❑ 3
Wash and dry your entire body?	❑ 0	❑ 1	❑ 2	❑ 3
Bend down and pick up clothing from the floor?	❑ 0	❑ 1	❑ 2	❑ 3
Turn regular faucets on and off?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of a car, bus, train or airplane?	❑ 0	❑ 1	❑ 2	❑ 3
Walk two miles if you wish?	❑ 0	❑ 1	❑ 2	❑ 3
Participate in recreational activities and sports as you would like, if you wish?	❑ 0	❑ 1	❑ 2	❑ 3

TOTAL SCORE_____(OFFICE USE)

1. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been: Please circle one number.

NO PAIN **PAIN AS BAD AS IT COULD BE**

0 1 2 3 4 5 6 7 8 9 10

2. How tired have you been OVER THE PAST WEEK? Please indicate how severe your fatigue has been: Please circle one number.

NO PROBLEM **VERY TIRED**

0 1 2 3 4 5 6 7 8 9 10

3. Considering all the ways in which illness and health conditions affect you at THIS TIME, please indicate below how you are doing. Please circle one number.

VERY WELL **VERY POORLY**

0 1 2 3 4 5 6 7 8 9 10

OFFICE USE:
VITALS: HT:_____**WT:**_____ **PULSE:**_____**RESP:**_____**BP:**_____

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REVISED 5/2016

RETURN PATIENT FORM

PATIENT NAME:_____**DATE:**_____

REASON FOR TODAY'S VISIT: _____
#DAYS OF WORK MISSED IN LAST MONTH DUE TO ARTHRITIC CONDITION: _____**(LEAVE BLANK IF UNEMPLOYED OR RETIRED)**
1. PAST HISTORY: MARK (X) IF ANY CHANGES AND LIST DETAILS ONLY IF CHANGES SINCE YOUR LAST VISIT.

NEW ILLNESS/TREATMENTS_____ NEW ALLERGIES_____ OPERATIONS:_____INJURIES:_____CURRENTLY PREGNANT::_____
NO CHANGES: _____
DETAILS::

2. FAMILY/SOCIAL HISTORY: PLEASE LIST ANY CHANGES SINCE YOUR LAST VISIT OF FAMILY, MARITAL STATUS, OCCUPATIONAL OR LIFESTYLE CHANGES INCLUDING EXERCISE FREQUENCY, CHANGES IN SMOKING OR ALCOHOL USE.
NO CHANGES:_____
DETAILS:

3. ADVANCED DIRECTIVE OF CARE - PLEASE MARK YES OR NO: ___NO ___YES Living Will ___No ___Yes
Power of Attorney: ___No ___Yes HEALTHCARE PROXY: ____No ____YES
NAME:_____**RELATIONSHIP:**_____
PH: (IF DIFFERENT FROM PT.)_____

4. HEALTH MAINTENANCE: MARK YES OR NO IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE PAST YEAR.
Flu Vaccine ____Yes Date:_____ Where?_____ ____No ____Declined
Pneumonia Vaccine ____Yes Date:_____ Where?_____ ____No ____Declined
Shingles Vaccine _____Yes Date:_____ Where? _____ ____No ____Declined
DEXA (bone density) ____ Yes Date:_____ Where?_____:_____
MARK (X) IF YOU HAVE HAD IN THE PAST YEAR: Chest x-ray_____Date:_____ Tuberculosis test (PPD/Quantiferon Gold test)_____Date:_____

5. HAVE YOU HAD ANY FALLS IN THE LAST YEAR? ___NO ____YES IF YES, HOW MANY? _____

REVIEW OF SYSTEMS	PLEASE MARK ALL SYMPTOMS YOU HAVE HAD RECENTLY		
GENERAL ❑ fever ❑ chills ❑ fatigue ❑ weight loss ❑ insomnia **EYES** ❑ vision loss ❑ dry eyes **EAR/NOSE/THROAT** ❑ nasal drainage ❑ mouth sores **RESPIRATORY** ❑ shortness of breath ❑ cough ❑ History of tuberculosis ❑ PPD positive	**CARDIOLOGY** ❑ chest pain ❑ palpitations **VASCULAR** ❑ leg swelling/edema ❑ Raynaud's **GASTROENTEROLOGY** ❑ nausea ❑ heartburn ❑ vomiting ❑ diarrhea ❑ difficulty swallowing ❑ constipation ❑ blood in stool ❑ black tarry stool **UROLOGY** ❑ painful urination ❑ blood in urine	**ENDOCRINE** ❑ heat intolerance ❑ cold intolerance ❑ hair loss **NEUROLOGY** ❑ headache ❑ tingling/numbness ❑ gait difficulties ❑ dizziness ❑ memory loss ❑ seizures **PSYCHOLOGY** ❑ emotional problems ❑ difficulty concentrating	**SKIN** ❑ rash ❑ sun sensitivity **MUSCULOSKELETAL** ❑ joint stiffness ❑ joint pain ❑ joint swelling ❑ muscle pain ❑ muscle weakness ❑ back pain ❑ neck stiffness **BLOOD/LYMPH** ❑ swollen glands ❑ easy bruising

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