Elliot Rheumatology Associates
Follow up visit
Date:

Name:	Age/Sex	MRN:

Since your last visit, have you had any of the following:

	Yes	No	If yes, please explain
Any new symptoms:			
Change in medical history			
Change in surgical history			
Change in family history			
Change in social history			
Have had new allergies			

Review of systems:
Please circle if you have any of the following :

General	Fever, Fatigue, Excessive sweating, Low appetite, Weight loss/gain
Skin	Rashes, Increased sun sensitivity
HEENT	Increased hair loss, Dry eyes, Dry mouth, Mouth sores
Pulmonary	Cough, Breathing difficulty
CVS	Chest pain/pressure, palpitation
GI	Abdominal pain, diarrhea, nausea, vomiting, Blood in the stools
Musculoskeletal	Joint pain, Muscle pain, Joint swelling, Morning stiffness
Heme	Blood clots, miscarriages, Abnormal bleeding/bruises
Ext	Raynaud's
Neuro	Headaches, sleep problems, numbness