R&O History Form for Established Patients **Today's Date:**_____

Name_____ **Date of Birth**_____

Primary Care Physician_____

Pharmacy Name & Location_____

Do you need any refills of medications today? If so, please indicate which ones:

Since your last visit:

Any surgeries or procedures? (please describe)

Any tests such as X-rays, CAT scans or MRIs? Where? (please describe)

Any lab work done? Where?

Any medication changes? (please be prepared to review with nurse)

Anything in your life causing you extra stress? (please describe)

Please review the following list. Check any problems which have significantly affected you since your last visit.

- ☐ Chills
- ☐ Cold or Flu Symptoms
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Changes
- ☐ Vision Changes
- ☐ Difficulty Swallowing
- ☐ Snoring
- ☐ Chest Pain/Pressure
- ☐ Breathing Trouble
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble with Urination
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Morning Stiffness
- ☐ Muscle Weakness
- ☐ Rash
- ☐ Headache
- ☐ Numbness & Tingling
- ☐ Restless Legs
- ☐ Trouble Falling Asleep
- ☐ Trouble Sleeping
- ☐ Waking Up Too Early

PLEASE ANSWER IF AGE 65 OR OLDER

Have you had the seasonal flu vaccine? ☐ Yes ☐ No
If yes, when & where?_____

Have you had the Prevnar13 Vaccine (PCV13)? ☐ Yes ☐ No
If yes, when & where?_____

Have you had the Pneumovax23 Vaccine (PPSV23)? ☐ Yes ☐ No
If yes, when & where?_____

Have you had a Bone Mineral Density Scan (DXA)? ☐ Yes ☐ No
If yes, when & where?_____