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Specialists in:

Arthritis
Carpal Tunnel
Syndrome
Fibromyalgia
Low Back Pain
Tendinitis

Bursitis
Connective Tissue
Disease
Gout
Osteoporosis
Vasculitis

PATIENT HISTORY FORM

Name: _____ Date: _____

Birth Date: _____ Referring Physician: _____

PCP: _____

Prior Rheumatologist? _____

Prior Orthopedist? _____

What is the problem that brought you here?

Health Problems: (Circle)

Hypertension

High Cholesterol

Heart Disease

Stroke

Diabetes

Thyroid Disease

Asthma

Chronic Bronchitis/Emphysema

Pneumonia

Liver Disease

Colitis/Crohn's Disease

Ulcers

Gastrointestinal bleeding

GERD/ Reflux/Hiatal Hernia

Glaucoma

Uveitis/Iritis

Anemia

Low white blood cells/platelets

Cancer/Leukemia

Kidney disease

Kidney stones

Tuberculosis

HIV/AIDS

Headaches/Migraines

Depression

Nervous Breakdown

Seizures/Epilepsy

Psoriasis

Sarcoidosis

Rheumatic Fever

Polio

PATIENT HISTORY FORM (cont)

Other Illnesses: (Please List)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT HISTORY FORM (cont)

Hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

When was your last TB test? _____ Never

Have you had a Bone Density Test? Yes / No When? _____

Circle your adult immunizations Influenza vaccine Date _____

Pneumonia vaccine Date _____

Hepatitis B Date _____

Shingles / Varicella vaccine Date _____

Medication Allergies/ Intolerance: (Please list the medicine and reactions)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATIENT HISTORY FORM (cont)

Social History

Marital status: Single Married Widowed Divorced Partner

Employment: _____

Education: **Grade School** 7 8 9 10 12 **College** 1 2 3 4 **Graduate School** _____

Smoking: No Yes Amount per day _____ Years _____ Quit, when? _____

Alcohol: No Yes Number per week _____
Have you ever felt you had to quit? Yes No

Recreational drug use? No Yes Drugs; _____

Hobbies/Activities: _____ Exercise regularly No Yes _____

Travel History

Have you travelled outside of the US in recent years? Yes / No Where and When?

PATIENT HISTORY FORM (cont)

Family History

Mother: Alive Deceased Age _____
Father: Alive Deceased Age _____
Siblings: Brothers _____ Sisters _____

Please circle items and mark Mother, **F**ather, **B**rother, **S**ister as needed

Hypertension	Tuberculosis
High Cholesterol	HIV/AIDS
Heart Disease	Headaches/Migraines
Stroke	Depression
Diabetes	Nervous Breakdown
Thyroid Disease	Seizures/Epilepsy
Asthma	Glaucoma
Chronic Bronchitis/Emphysema	Uveitis/Iritis
Pneumonia	Psoriasis
Liver Disease	Sarcoidosis
Colitis/Crohn's Disease	Rheumatic Fever
Ulcers	Arthritis/ Rheumatoid
GERD/ Reflux/Hiatal Hernia	Lupus
Anemia	Autoimmune disease
Cancer/Leukemia	List _____

Kidney disease	
Kidney stones	

Other Family History

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATION LIST

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____