Name: Married Never Married Date of Birth: Gender: Male Female Registry Morking Retired Namital Status: Married Never Married Divorced Separated Wildowed Partner/Significant Other Feducation: (Gircle highest attended) Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: Referred By: Self Family Friend Doctor Other Health Professional Name:	Patient Medical Histo	ry								Date:	/	/
Marital Status: Married Never Married Divorced Separated Widowed Partner/Significant Other Education: Circle highest attended Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School:	Name:					Date o	f Birth:			Gende	er: 🗆 N	1ale □ Female
Married Status: Married Never Married Divorced Separated Wildowed Partner/Significant Other Education: Circle highest attended Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School: Name: Name:	Height:	Weight:				Age:				Work: ☐ Working ☐ Retired		
Referred By: Self Family Friend Doctor Other Health Professional Name: N										g .		
Referred By: Self Family Friend Doctor Other Health Professional Rheumatologic (Arthritis) History: At any time, have you or a blood relative had any of the following?: (Check if "Yes") Vourself Relative / Relationship Vourself Relative / Relationship												
Relative / Posterious / Relative / Posterious / Relative / Relative / Relative / Relative / Posterious / Relative / Relative / Relative / Posterious / Relative / Relative / Relative / Posterious / Relative / Posterious / Relative												
Arthritis (Unknown Type)	<u> </u>	,										
Arthritis (Unknown Type)	Rheumatologic (Arthritis	s) History: At	any time, h	ave yo	u or a blo	od relat	ive had	any of th	ne follov	ving?: (Ch	neck if "Ye	s")
Osteoprosis		Yourself	Relative /	Relatio	onship					Yourself	Relative	Relationship
Gout	Arthritis (Unknown Type) 🗆	□/			Ankylo	sing Sp	ondylitis			\Box /	
Gout	Osteoarthritis					Osteo	porosis					
Lupus or "SLE"	Gout					Rheun	natoid <i>i</i>	Arthritis				
Psoriasis/Psoriatic Arthritis	Childhood Arthritis					Sjogre	n's Dise	ease				
Other arthritis conditions:	Lupus or "SLE"											
Other arthritis conditions: Social History: Do you drink caffeinated beverages? Yes No Cups/glasses per day?	Description (Description Authority	L:- 🗆				Inflam	· · ·					
Social History: Do you drink caffeinated beverages? Yes	Psoriasis/Psoriatic Arthri	tis		/								
Do you drink caffeinated beverages? Yes	Other arthritis condition	s:										
Do you drink caffeinated beverages? Yes												
Do you smoke? Do you drink alcohol? Has anyone ever told you to cut down on your drinking? Do you use drugs for reasons that are not medical? Do you exercise regularly? Do you exercise regularly? Do you get enough sleep at night? Past Medical History: Past Medical History: Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you wake up feeling rested? Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems Bad Headaches Asthma Leukemia Cataracts Cancer HIV/AIDS Jaundice Goiter Nervous Breakdown Tuberculosis Epilepsy Emphysema Pneumonia Psoriasis Rheumatic Fever Stomach Ulcers Diabetes Glaucoma Collitis Anemia Heart Murmur Kidney Stones Pulmonary Embolism Epilepsy (seizures) Crohn's Disease Hepatitis Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living If Deceased Age Health Age at Death Cause	•											
Do you drink alcohol? Has anyone ever told you to cut down on your drinking? Yes No If yes, list: Do you use drugs for reasons that are not medical? Yes No If yes, list: Do you get enough sleep at night? Yes No How many hours? Do you wake up feeling rested? Yes No How many hours? Past Medical History: Do you make up feeling rested? Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems Bad Headaches Asthma Leukemia Cataracts Cancer High Blood Pressure Kidney Disease Stroke HIV/AIDS Jaundice Goiter Nervous Breakdown Tuberculosis Epilepsy Emphysema Pneumonia Psoriasis Rheumatic Fever Stomach Ulcers Diabetes Glaucoma Colitis Anemia High Cholesterol Hypothyroidism Angina Heart Murmur Kidney Stones Pulmonary Embolism Epilepsy (seizures) Crohn's Disease Hepatitis Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living If Deceased Age Health Age at Death Cause	•	beverages?			Yes □	<u> </u>			?			
Has anyone ever told you to cut down on your drinking? Yes No	-											
Do you use drugs for reasons that are not medical? Yes	•					*						
Do you exercise regularly? Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems Bad Headaches Asthma Leukemia Cataracts Cancer High Blood Pressure Kidney Disease Stroke HIV/AIDS Jaundice Goiter Provincias Epilepsy Emphysema Proeumonia Procincias Anemia Heart Murmur Kidney Stones High Cholesterol Hypothyroidism Angina Heart Murmur Kidney Stones Pulmonary Embolism Epilepsy (seizures) Crohn's Disease Hepatitis Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): If Living If Deceased Age Health Age at Death Cause												
Do you get enough sleep at night? Yes No How many hours? Do you wake up feeling rested? Yes No C Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems Bad Headaches Asthma Leukemia Cataracts Cancer High Blood Pressure Kidney Disease Stroke HIV/AIDS Jaundice Goiter Nervous Breakdown Tuberculosis Epilepsy Emphysema Pneumonia Psoriasis Rheumatic Fever Stomach Ulcers Diabetes Glaucoma Colitis Anemia High Cholesterol Hypothyroidism Angina Heart Murmur Kidney Stones Pulmonary Embolism Epilepsy (seizures) Crohn's Disease Hepatitis Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living If Deceased Age Health Age at Death Cause												
Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems									r week:			
Past Medical History: Do you now have, or have you ever had, any of the following?: (Check if "Yes") Heart Problems												
Heart Problems	Do you wake up reeling re	esteur			Yes □	NO L						
Heart Problems			-									
High Blood Pressure	_								eck if "Y			
Nervous Breakdown Tuberculosis Epilepsy Emphysema Pneumonia Psoriasis Rheumatic Fever Stomach Ulcers Diabetes Glaucoma Colitis Anemia High Cholesterol Hypothyroidism Angina Heart Murmur Kidney Stones Pulmonary Embolism Epilepsy (seizures) Crohn's Disease Hepatitis Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living If Deceased Age Health Age at Death Cause Colitis Anemia Psoriasis Pleasures Pneumonia Psoriasis Pleasures Pneumonia Psoriasis Anemia Psoriasis Pneumonia Psoriasis Pleasures Pneumonia Psoriasis Anemia Psoriasis Pneumonia Psoriasis Pleasures Pneumonia Psoriasis Pleasures Pneumonia Psoriasis Anemia Psoriasis Pneumonia Pneumonia Pneumonia Psoriasis Pneumonia Pneum												
Rheumatic Fever		-	·									
High Cholesterol					· · · · ·							
Pulmonary Embolism												☐ Anemia
Other significant illnesses (please list): Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living Age Health Age at Death Cause		,, ,			_					☐ Kianey Stones		
Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.): Family Medical History If Living Age Health Age at Death Cause			(seizures)	□ Cr	ohn's Dis	sease	⊔ Hep	oatitis				
Family Medical History If Living If Deceased Age Health Age at Death Cause												
If Living If Deceased Age Health Age at Death Cause	Natural or Alternative Th	erapies (chiro	practic, mag	gnets, r	massage,	over-the	e-coun	ter prepa	rations,	etc.):		
If Living If Deceased Age Health Age at Death Cause												
If Living If Deceased Age Health Age at Death Cause												
If Living If Deceased Age Health Age at Death Cause	Formily Modical History											
Age Health Age at Death Cause	Family Medical History			If Dococood								
	100											
raulci		Health				Age at Death				Cause		
Mother												

Health of Children:

Number Living:

Number Living:

Number of Siblings:

Number of Children:

Previous Surgeries												
Туре	Ye	ar	Reaso	Reason								
Any previous fractures? Yes □	Describe:		•									
Any other serious injuries: Yes	Describe:											
	•											
Drug Allergies: Yes □ No □ If	ves please	list drugs	helow									
	Reaction	1131 41 453	BCIOW	•	Drug		Reaction					
2.28	Neaction				2145		Treatment on					
L												
Present Medications												
				F			Herr	. Lana Talan				
Drug Name	Dose			Frequ	iency		HOW	Long Taken				
Supplement/Vitamin/Herb	Dose	Fre	equenc	су	Supplement/Vitar	min/Herb	Dose	Freque	ncy			
		l					l .	l .				
Date of last mammogram:	/	/					Hepatitis	Vaccino				
Date of last mammogram: / / /			_		coccal Vaccine	lo 🗆						
Date of last eye exam: / / /			_	Prevnar		Hepatitis						
Date of last chest x-ray: / / / Date of last Turberculosis Test: / /				Pneumo	vax 23 Yes □ N	lo 🗆	Hepatitis	B Yes [□ No □			
				al •		Year						
Date of last bone densitometry (DXA Scan):	/			Vaccine	real							
(5701 30011).			2	∠ostavax	∢ Yes □ No □							

Shingrix

Yes □ No □