Patient Medical History **Date: _____ /_____ / ____**

Name:		**Date of Birth:**		**Gender:**	☐ Male ☐ Female
Height:	**Weight:**		**Age:**	**Work:**	☐ Working ☐ Retired
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: _____				
Referred By:	☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional			**Name:**	

Rheumatologic (Arthritis) History: At any time, have <u>you</u> or a <u>blood relative</u> had any of the following? : (Check if "Yes")					
	Yourself	**Relative /Relationship**		**Yourself**	**Relative /Relationship**
Arthritis (Unknown Type)	☐	☐ /	Ankylosing Spondylitis	☐	☐ /
Osteoarthritis	☐	☐ /	Osteoporosis	☐	☐ /
Gout	☐	☐ /	Rheumatoid Arthritis	☐	☐ /
Childhood Arthritis	☐	☐ /	Sjogren's Disease	☐	☐ /
Lupus or "SLE"	☐	☐ /	Raynaud's Syndrome	☐	☐ /
Psoriasis/Psoriatic Arthritis	☐	☐ /	Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)	☐	☐ /
Other arthritis conditions:					

Social History:			
Do you drink caffeinated beverages?	Yes ☐ No ☐	Cups/glasses per day?	
Do you smoke?	Yes ☐ No ☐	How long ago?	
Do you drink alcohol?	Yes ☐ No ☐	Number per week?	
Has anyone ever told you to cut down on your drinking?	Yes ☐ No ☐		
Do you use drugs for reasons that are not medical?	Yes ☐ No ☐	If yes, list:	
Do you exercise regularly?	Yes ☐ No ☐	Type and Amount per week:	
Do you get enough sleep at night?	Yes ☐ No ☐	How many hours?	
Do you wake up feeling rested?	Yes ☐ No ☐		

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**
Father						
Mother						
Number of Siblings:		**Number Living:**		**Health of Children:**		
Number of Children:		**Number Living:**				

Previous Surgeries		
Type	**Year**	**Reason**

Any previous fractures? Yes ☐ No ☐	Describe:
Any other serious injuries: Yes ☐ No	Describe:

Drug Allergies: Yes ☐ No ☐ If yes, please list drugs below:			
Drug	**Reaction**	**Drug**	**Reaction**

Present Medications			
Drug Name	**Dose**	**Frequency**	**How Long Taken**

Supplement/Vitamin/Herb	Dose	Frequency	Supplement/Vitamin/Herb	Dose	Frequency

Date of last mammogram:	____/ ____/ ____
Date of last eye exam:	____/ ____/ ____
Date of last chest x-ray:	____/ ____/ ____
Date of last Turberculosis Test:	____/ ____/ ____
Date of last bone densitometry (DXA Scan):	____/ ____/ ____

Pneumococcal Vaccine		
Prevnar 13	Yes ☐	No ☐
Pneumovax 23	Yes ☐	No ☐

Hepatitis Vaccine		
Hepatitis A	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐

Shingles Vaccine			Year
Zostavax	Yes ☐	No ☐	
Shingrix	Yes ☐	No ☐	