PATIENT HISTORY FORM

Name		DOB	
Allergies			

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "Yes")

	YOURSELF	RELATIONSHIP		YOURSELF	RELATIONSHIP
Arthritis			Lupus of "SLE"		
Osteoarthritis			Rheumatoid Arthritis		
Gout			Ankylosing Spondylitis		
Childhood Arthritis			Osteoporosis		

Other arthritis conditions:

SOCIAL HISTORY

Occupation:

Do you smoke? Yes ___ No___ Past___ How long ago? _____ How many years? _____ Packs per day? _____

Do you drink alcohol? Yes___ No___ Number per week_____

Do you use drugs for reasons that are not medical? Yes____ No____

If yes, please list:

Do you exercise regularly? Type: Amount per week:

SURGICAL HISTORY		**IMMUNIZATION HISTORY**		
TYPE	**YEAR**	**TYPE**	**YES/NO?**	**DATE GIVEN**
		Flu Shot		
		Pneumonia Shot		
		COVID-19		
		Shingles		

NAMES OF ALL OTHER PHYSICIANS YOU ARE CURRENTLY SEEING

PAST MEDICAL HISTORY

Do you now have or ever had? Check all that apply.					
Cancer		Heart Problems		Asthma	
Goiter		Leukemia		Stroke	
Cataracts		Diabetes		Epilepsy	
Nervous Breakdown		Stomach Ulcers		Rheumatic Fever	
Bad Headaches/ Migraines		Jaundice		Colitis	
Kidney Disease		Pneumonia		Psoriasis	
Anemia		HIV/AIDS		High Blood Pressure	
Emphysema		Glaucoma		Tuberculosis	
High Cholesterol					

Any additional comments please use back of this form.