NAME: DATE OF INITIAL VISIT:

1. PLEASE DESCRIBE YOUR CHIEF MEDICAL COMPLAINT BRIEFLY:

2. PAST MEDICATIONS TAKEN FOR ARTHRITIS:

Name of Medication	Dose (mg)	Taken how long?	Results

3. CURRENT MEDICATIONS FOR ARTHRITIS:

Name of Medication	Dose (mg)	Taken how long?	Results

4. OTHER REGULAR MEDICATIONS:

Name of Medication	Dose (mg)	Taken how long?	Results

5. CURRENT MEDICAL CONDITIONS AND/OR SURGERY: (Give diagnosis and dates)

6. ALLERGIES TO MEDICATIONS: (Please list)

7. FAMILY HISTORY:

Relationship:	Medical conditions or cause of death:
Father	
Mother	
Brother/Sisters	
Children (ages)	

8. SOCIAL HISTORY

A. Smoking Status

- Current every day smoker ☐ No ☐ Yes _____ (packs per day)
- Current some day smoker ☐ No ☐ Yes _____ (packs per day)
- Former smoker ☐ No ☐ Yes _____ (packs per day)
- Never smoked ☐

B. Do you drink alcohol? ☐ No ☐ Yes _____ (drinks per day)

C. Occupation? _____ Retired? ☐ No ☐ Yes

9. **VACCINE HISTORY**

A: Influenza (flu) vaccine:

☐ No

☐ Yes Date received _____

B: Pneumonia vaccine

☐ No

☐ Yes Date received _____

10: **DEXA SCAN AFTER THE AGE OF 60?**

☐ No

☐ Yes Date of scan _____

11. **REVIEW OF SYSTEMS** - (Please place check mark (✓) next to all that apply):

SKIN

☐ psoriasis
☐ other rash
☐ rash from sun
☐ fingers turn white or blue in cold
☐ easy bruising
☐ abnormal loss of hair
☐ sores on fingertips
☐ tick bites

EYES

☐ dry eyes
☐ redness of eyes
☐ loss of vision
☐ eye pain or history of uveitis

EARS, NOSE & THROAT

☐ dry mouth
☐ frequent mouth ulcers
☐ frequent earaches
☐ frequent nasal ulcers
☐ recent dental cavities or infection
☐ swelling or pain on sides of face

RESPIRATORY

☐ asthma
☐ chronic cough
☐ chest pain
☐ shortness of breath
☐ cough up sputum

ENDOCRINE

☐ thyroid disease
☐ diabetes mellitus

NEUROLOGIC

☐ headaches
☐ tingling in fingers
☐ seizures
☐ stroke
☐ pain, tingling or numbness in one leg
☐ muscle weakness

CARDIOVASCULAR

☐ angina
☐ heart attack
☐ heart murmur
☐ rheumatic fever
☐ fluid retention or swelling of feet
☐ abnormal heart rhythm
☐ phlebitis
☐ congestive heart failure
☐ high blood pressure

GASTROINTESTINAL

☐ stomach or duodenal ulcer
☐ heartburn
☐ difficulty swallowing
☐ nausea or vomitting
☐ chronic diarrhea
☐ abdominal pain
☐ weight loss
☐ gallstones
☐ jaundice
☐ hepatitis or liver disease
☐ bleeding from stomach or bowel

GENITOURINARY

☐ urinary burning
☐ urinary frequency
☐ blood in urine
☐ protein in urine
☐ sores or rash on penis or vagina
☐ discharge from penis or vagina
☐ miscarriages (#_____)
☐ kidney stones

CONSTITUTIONAL

☐ fevers
☐ fatigue
☐ difficulty sleeping
☐ illict drug use (past or present)

HEMATOLOGIC

☐ anemia
☐ low platelet count
☐ history of cancer

ALLERGIC

☐ allergy shots
☐ food allergies

PSYCHIATRIC

☐ depression

☐ **NONE OF THE ABOVE**

REVIEWED BY:

_____, M.D.