

PATIENT'S PERSONAL HISTORY

Account No _____

Date _____

Confidential record and information contained here will not be released except when you have authorized us to do so.

Last Name		First	Middle	Sex	DOB
Address		City	State	ZIP	Home Phone Business Phone
Occupation	Medicare No.		Medicaid No.		Marital Status

Primary Insurance Company and ID Number: _____

Secondary Insurance Company (companies) and ID Number(s): _____

Person to notify in case of emergency: _____ Phone: _____

Relationship: _____ Address: _____

Date of last physical examination _____ Physician _____

Family Physician _____ Referring Physician: _____

Address _____ Address: _____

Describe briefly your present symptoms: _____

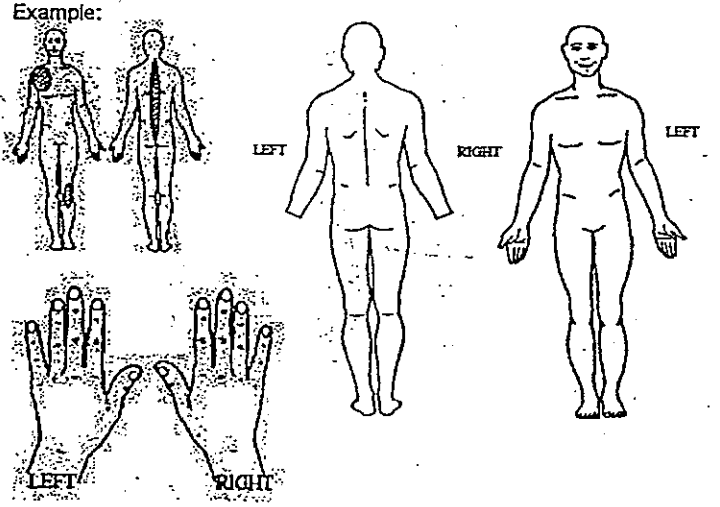
Date symptoms began _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications will be listed later)

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain over the past week on the body figures and hands.



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritic conditions: _____

Signature _____

Date _____

SOCIAL HISTORY:

Do you drink caffeinated beverages? cups/glasses per day _____
 Do you smoke? Yes No Past - 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, please list: _____

Do you exercise regularly? Yes No
 Type _____
 Amount per week _____
 How many hours of sleep do you get at night? _____
 Do you get enough sleep at night? Yes No
 Do you wake up feeling rested? Yes No

PAST MEDICAL HISTORY:

Do you now or have you ever had; (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, acupuncture, etc.) _____

PREVIOUS OPERATIONS

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____ Cause of death _____
 Number of children _____ Number living _____ Number deceased _____ List ages of each _____
 Health of children _____

Do you know of any blood relative who has or had (check and given relationship):

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

Signature _____

Date _____

MEDICATIONS

ALLERGIES:

<i>Name of Drug</i>	<i>Reaction</i>
1.	
2.	
3.	
4.	
5.	

PRESENT MEDICATIONS: (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium or other supplements):

Name of Drug	Dose (Include strength & no. of pills per day)	How long have you taken this medication?	Please check: Helped?		
			A lot	Some	Not at all
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ARTHRITIS MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, *How long* you were taking the medication, the *results* of taking the medication, and list any *reactions* you may have had. Record your comments in the spaces provided.

Drug Names./Dosage	Length of Time	Please check: Helped?			Reactions
		A lot	Some	Not at all	
Nonsteroidal AntiInflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinoril (sulfindac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feldene (prixocam)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin/Rufen (Ibuprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tolectin (tolmetin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrotec (Dilofenac + Misoprostol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DayPro (oxaprozin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indochin (Indomethacin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nalfon (fenoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trilisate (choline magnesium trisilicate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin (including coated aspirin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Drug Names./Dosage	Length of Time	Please check: Helped?			Reactions
		A lot	Some	Not at all	
Disalcid (salsalate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lodine (etodolac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naprosyn (naproxen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vioxx (rofecoxin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Celebrex (Celecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dolobid (diflunisal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meclomen (meclofenamate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oruvail (ketoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voltaren (diclofenac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Relievers:					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol #3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysin or Solganal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>DMARDS continued</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosurba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis Medications:					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Drug Names./Dosage	Length of Time	Please check: Helped?			Reactions
		A lot	Some	Not at all	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin Injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications:					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others:					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or nutritional supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					