Mark Fisher, M.D. F.A.C.R.

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: _____

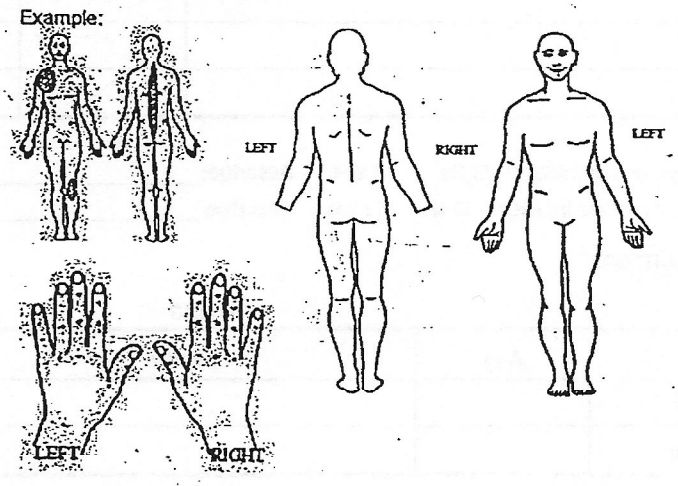
Date symptoms began _____

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")*

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High blood pressure
☐ Emphysema	☐ Glaucoma	☐ 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):

☐ Cancer _____ ☐ Heart disease _____ ☐ Rheumatic fever _____ ☐ Tuberculosis _____

☐ Leukemia _____ ☐ High blood pressure _____ ☐ Epilepsy _____ ☐ Diabetes_____

☐ Stroke _____ ☐ Bleeding tendency_____ ☐ Asthma_____ ☐ Goiter _____

☐ Colitis _____ ☐ Alcoholism_____ ☐ Psoriasis_____

_____ _____

Signature Date

MEDICATIONS

ALLERGIES:

Name of Drug	*Reaction*
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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10			☐	☐	☐

PAST 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? A lot	Some	Not at all	Reactions
Nonsteroidal Antiinflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		☐	☐	☐	
Clinoril (sulindac(		☐	☐	☐	
Feldene (prixocam)		☐	☐	☐	
Motrin/Rufen (ibuprofen)		☐	☐	☐	
Tolectin (tolmetin)		☐	☐	☐	
Arthrotec (Diiofenac + Misoprostol)		☐	☐	☐	
DayPro (oxaprozin)		☐	☐	☐	
Indocin (indomethacin)		☐	☐	☐	
Nalfon (fenoprofen)		☐	☐	☐	
Trilisate (choline magnesium trisilicate)		☐	☐	☐	
Aspirin (including coated aspirin)		☐	☐	☐	