

**New Patient History Form**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 (Last) (First) (MI) (Maiden) (MM/DD/YYYY)

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
 Street Apt#  
 \_\_\_\_\_  
 City State Zip

**MARITAL STATUS:**  Never Married  Married  Divorced  Separated  Widowed

Spouse/Significant Other: Name \_\_\_\_\_

**EDUCATION** (Circle highest level attended): Grade School 7 8 9 10 11 12 College 1 2 3 4  Graduate School

Occupation \_\_\_\_\_ Number of hours worked/average per week \_\_\_\_\_

Employer \_\_\_\_\_

Referred here by: (check one)  Self  Family  Friend  Doctor  Other Health Professional

Name of person making referral: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Are you on disability? Y  N  Applying/or planning to apply for disability? Y  N

Are you currently or have you been involved in a medically related lawsuit? Y  N

Describe briefly your present symptoms: \_\_\_\_\_

\_\_\_\_\_

Date symptoms began (approximate): \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later): \_\_\_\_\_

\_\_\_\_\_

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

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

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

Yourself	Relative/Relationship	Yourself	Relative/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or SLE
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

### SYSTEM REVIEW

Date of last chest x-ray \_\_\_\_\_ Date of last Tuberculosis Test \_\_\_\_\_ Date of last bone densitometry \_\_\_\_\_

As you review the following list, please check any of these problems which have significantly affected you.

#### Constitutional

- Fatigue
- Fever
- Chills
- Night Sweats
- Hot flashes
- Recent weight loss amount \_\_\_\_\_
- Recent weight gain amount \_\_\_\_\_

#### Eyes-Ears-Nose-Mouth-Throat

- Dry eyes
- Itchy eyes
- Eye pain
- Eye Inflammation
- Vision changes
- Blurred vision
- Double vision
- Dry mouth
- Mouth sores
- Mouth ulcers
- Excessive dental decay
- Hoarseness
- Sinus Problems
- Runny nose
- Parotid Swelling
- Hearing loss
- Ringing in ears

#### Respiratory

- Chronic cough
- Cough
- Shortness of breath at rest
- Shortness of breath with activity
- Difficulty breathing at night
- Pleurisy
- Coughing up blood
- Wheezing (asthma)

#### Cardiovascular

- Chest pain
- Chest pressure
- Swollen legs or feet (edema)
- Irregular heart beat
- Heart palpitations
- Color chgs of hands or feet in cold

#### Endocrine

- Excessive hair loss
- Male pattern hair loss
- Excessive thirst

#### Gastrointestinal

- Stomach pain
- Difficulty swallowing
- Vomiting of blood or coffee ground material
- Blood in stools
- Black stools
- Constipation
- Persistent diarrhea
- Heartburn
- Reflux
- Nausea
- Decreased appetite

#### Genitourinary

- Cloudy, "smoky" urine
- Pain or burning on urination
- Blood in urine
- Getting up at night to pass urine
- Rash/ulcers
- Abnormal discharge from penis/vagina

#### For Women Only:

- Periods regular? Y N
- Date of last period? \_\_\_\_\_
- Number of pregnancies? \_\_\_\_\_
- Number of miscarriages? \_\_\_\_\_

#### Neurological System

- Dizziness
- Lightheadedness
- Vertigo
- Numbness
- Tingling
- Headaches
- Jaw cramping when chewing
- Scalp tenderness
- Memory Loss
- Seizures

#### Psychiatric

- Anxiety
- Depression
- Suicidal thoughts
- Difficulty falling asleep
- Difficulty staying asleep
- Wake up tired in morning

#### Skin

- Hives
- Rash
- Sun sensitive (sun allergy)
- Psoriasis
- Nodules
- Tightness/thickening

#### Musculoskeletal

- Back pain
- Neck pain
- Joint pain
- Joint swelling
- Muscle pain
- Muscle tenderness
- Muscle weakness
- Morning stiffness lasting how long?  
mins \_\_\_\_\_ hours \_\_\_\_\_

List joints affected in the last 6 months

Any previous fractures? Y N

Which bone/cause of fracture:

Height loss

What was the tallest height you have ever been? FT \_\_\_\_\_ IN \_\_\_\_\_

Any other serious injuries? Y N

Please describe:

#### Hematologic/Lymphatic

- Easy bruising
- Easy bleeding
- Blood clots
- Anemia
- Swollen glands

#### Allergic/Immunologic

- Frequent sneezing
- Environmental allergies
- Food allergies
- Seasonal allergies
- Frequent infections
- Recent infection

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

### Social History

Do you drink caffeinated beverages? Y  N   
 Cups/glasses per day? \_\_\_\_\_  
 Do you smoke? Y  N  Previous smoker? Y  N   
 When did you stop? \_\_\_\_\_  
 Do you drink alcohol? Y  N  Number per week \_\_\_\_\_  
 Has anyone ever told you to cut down on your drinking?  
 Y  N   
 Do you use drugs for reasons that are not medical?  
 Y  N   
 If yes, please list \_\_\_\_\_  
 \_\_\_\_\_  
 Do you exercise regularly? Y  N   
 Type \_\_\_\_\_  
 Amount per week \_\_\_\_\_  
 How many hours of sleep do you get at night? \_\_\_\_\_  
 Do you get enough sleep at night? Y  N   
 Do you wake up feeling rested? Y  N

### 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"/> Thyroid Problems	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Migraine	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Prostate problems	

Other significant illness (please list) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Previous Operations

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

### Family History

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

Number of siblings \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_  
 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 give relationship)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding Tendency _____	<input type="checkbox"/> Psoriasis _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Diabetes _____	

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

**MEDICATIONS**

Drug allergies: Y  N  To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxative, calcium and other supplements, etc)

Name of Drug	Dose (Include strength & number 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.					

**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 comment in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
<b>Pain Relievers</b>					
Acetaminophen (Tylenol)					
Codeine(Vicodin, Tylenol 3)					
Ultram(Tramadol/ultracet)					
Other:					
<b>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Ridaura (Auranofin, gold pills)					
Gold shots (Myochrysine or Solganol)					
Plaquenil (Hydroxychloroquine)					
Penicillamine (Cuprimine or Depen)					
Methotrexate (Rheumatrex)					
Imuran (Azathioprine)					
Sulfasalazine (Azulfidine)					
Arava (Leflunomide)					
Cytosan (Cyclophosphamide)					
Cyclosporine A (Sandimmune or Neoral)					
Enbrel (Etanercept)					
Remicade (Infliximab)					
Humira (Adalimumab)					
Simponi (Golimumab)					
Cimzia (Certolizumab)					
Orencia (Abatacept)					
Actemra (Tocilizumab)					
Rituxan (Rituximab)					
Other:					
Other:					

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**PAST MEDICATIONS Continued...**

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
<b>Osteoporosis Medications</b>					
Estrogen (Premarin, etc.)					
Fosamax (Alendronate)					
Actonel (Risedronate)					
Forteo (Teriparatide)					
Evista (Raloxifene)					
Calcitonin injections or nasal (Miacalcin, Calcimar)					
Boniva (Ibandronate)					
Reclast (Zoledronic Acid)					
Prolia (Denosumab)					
Other:					
<b>Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)</b>					
Ansaid (flurbiprofen)					
Arthrotec (diclofenac + misoprostol)					
Aspirin (including coated aspirin)					
Celebrex (celecoxib)					
Daypro (oxaprozin)					
Disalcid (salsalate)					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Indocin (indomethacin)					
Lodine (etodolac)					
Mobic (Meloxicam)					
Motrin/Rufen (ibuprofen)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Relafen (nabumetone)					
Tolectin (tolmetin)					
Vimovo (Naproxen + esomeprazole)					
Voltaren (diclofenac)					
Other:					
<b>Gout Medications</b>					
Probenecid (Benemid)					
Colchicine					
Allopurinol (Zyloprim/Lopurin)					
Febuxostat (Uloric)					
Other:					
<b>Others</b>					
Tamoxifen (Nolvadex)					
Cortisone/Prednisone/Medrol					
Hyalgan/Synvisc/Supartz/Euflexxa injections					
Herbal or Nutritional Supplements					
Please list supplements:					

All 5 pages completed by: \_\_\_\_\_ Relationship: Patient Spouse Parent Other  
Print Name

\_\_\_\_\_  
Signature Date: \_\_\_\_\_