PATIENT MEDICAL INFORMATION

Date _____ Birthdate _____ Age _____

Patient Name _____ M / F (circle one)

Pharmacy Name _____ Phone # _____

Medication Allergies (List drug name and reaction)

1) _____ 2) _____

3) _____ 4) _____

Past Surgical History (Includes biopsies, D&C's, tonsillectomy, etc.)

1) _____ 2) _____

3) _____ 4) _____

Medical Problems (Past and Present: include serious injuries and any fractures)

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Current Medication with Dosage (Including Non-Prescription drugs)

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

OB-GYN History

of Pregnancies _____ # Live Births _____ # of Stillborn/Miscarriages _____ Last GYN Exam _____

Name of your gynecologist: _____

Have you gone through menopause? Yes _____ No _____

If so, what age? _____

When was your last mammogram? _____

Other

When was your Chest X-ray? _____

Date of most recent immunizations: tetanus _____ flu _____ pneumonia _____

Have you had a DEXA scan? Yes _____ No _____

If so, when was your last scan? _____

When was your last PPD (TB skin test)? _____

Positive _____ Negative _____

PATIENT MEDICAL INFORMATION

Patient Name _____

Date of Birth _____

Family History

Please list the relationship to you of "Blood Relatives" who have had the following diseases.

Diabetes _____ Arthritis _____

Rheumatoid Arthritis _____ Cancer _____

High Blood Pressure _____ Lupus _____

Heart Disease _____ Gout _____

Kidney Disease _____ Other _____

Thyroid Disease _____ Psoriasis _____

Osteoporosis _____

Social History

Marital Status _____ # of Children _____

Hobbies or interests _____

Last grade of school completed _____

Describe occupation _____

Sources of unusual stress _____

# of cigarettes smoked per day _____ # of alcoholic drinks per day _____ # cups of coffee per day _____

Do you or have you ever used recreational drugs? _____

What is your exercise program? _____

How many days/week do you exercise? _____

Activities of Daily Living

List daily activities with which you have trouble because of your arthritis or muscle pain (eg: combing hair, bathing, kitchen activities, yard work, etc.) _____

_____

_____

**Please list the physician who should get copies of your office visits:

Doctor: _____ Address: _____

Doctor: _____ Address: _____