Patient Name:____________________________________ Date: ________________

PLEASE LIST ALL MEDICAL PROBLEMS THAT ANY PHYSICIAN TREATS NOW OR IN THE PAST
(REASONS YOU TAKE MEDICATIONS?)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

PLEASE LIST ALL VITAMINS, OVER THE COUNTER, AND PRESCRIPTION MEDICATIONS AND THEIR DOSAGES
(WHAT ARE YOU TAKING FOR YOUR MEDICAL PROBLEMS LISTED ABOVE?)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

LIST ANY MEDICATION ALLERGIES/REACTIONS

______________ _______ _______

______________ ____________

LIST ALL SURGERIES/PROCEDURES/HOSPITALIZATIONS

____________________ ____________________

____________________ ____________________

Family History:

Has any blood relative ever had? If so who?

Rheumatoid Arthritis	☐ No	☐ Yes		Other Family History:
Lupus	☐ No	☐ Yes		
Cancer	☐ No	☐ Yes		
Autoimmune disease	☐ No	☐ Yes		

Social History:

Occupation_____________________________________

Any Miscarriages or Blood Clots? ☐ Yes ☐ No

Married ☐ Single ☐ Widowed ☐ Divorced ☐

Do you now or have you ever? (Please check No or Yes and specify)

Use Illicit Drugs	☐ No	☐ Yes	
Use Tobacco Products	☐ No	☐ Yes	
Drink Alcohol	☐ No	☐ Yes	

Please inform your health care provider of any cultural or spiritual issues that may affect your care.