Name:_____ Date: _____
Doctor: _____

New Patient Information

Describe your current problem:

List the medications that you take (include over the counter medicines):

List the medicines you are allergic to:

Past Medical History

List all previous surgical procedures and hospitalizations:

Procedure/Diagnosis	Year
_____	____
_____	____
_____	____
_____	____
_____	____
Last Complete Physical Exam _____	____

Symptoms and medical conditions (please check positives):

____Asthma
____High Blood Pressure
____Diabetes
____Heart condition
____Thyroid Problem
____Ulcer
____Gastritis
____Seizure
____Stroke
____Mood Disturbance
____Colitis
____ Kidney Stones
____ Cancer

____Weight Change
____Rash/Skin Condition
____Frequent Headaches
____Dry Mouth or Eyes
____Heartburn/Acid Reflux
____Diarrhea or Constipation
____Visual Disturbance
____Depression or Anxiety
____Sleep Disturbance
____Persistent Fatigue
____Morning Stiffness
____Unexplained Fevers

____ Ulcer or Sores in your Mouth
____ Hands Turn Red, Blue or White With Cold Exposure
____ Rash with Sun Exposure
____ Cough or Other Lung Symptoms
____ Pronounced Hair Loss

Date: _____

Name: _____ Doctor: _____

Family History

Family Member	Alive	Deceased	Cause of Death/Medical Condition
Mother	____	____	_____
Father	____	____	_____
Sister/Brother	____	____	_____
Sister/Brother	____	____	_____
Sister/Brother	____	____	_____
Your Child	____	____	_____
Your Child	____	____	_____
Your Child	____	____	_____

Do you have any family members with arthritis or a rheumatic disease (Lupus, Rheumatoid Arthritis, etc.):

Social History

Describe your work or principle daily activities:

What are your exercise habits?

Are there things in your daily routine that aggravate your condition?

Do you smoke?

Do you drink alcohol? If so, estimate average weekly intake:

Is stress a major problem in your life?