Center for Arthritis and Osteoporosis

Medical History Sheet

Today's Date: _____
Name: _____ Date of Birth: _____
Primary Physician: _____ Referring Physician: _____
Reason for today's visit: _____
Please describe the problem which troubles you the most:
_____
_____

Joint pain Y / N
How long have you had it? _____
Location of pain: _____
Worse in: AM / PM

Type of pain: Dull / Aching / Sharp
Severity: Mild / Mod / Severe
Worse with: Rest / Walking / Movements
Swelling of joints Y / N

System Review

Do you have any of these problems currently?
Please circle yes or no.

General	
Recent weight gain	Y/N
Amount: _____	
Recent weight loss	Y/N
Amount: _____	
Fever	Y/N
Weakness/Fatigue	Y/N
Ears	
Ringing in ears	Y/N
Loss of hearing	Y/N
Eyes	
Pain	Y/N
Redness	Y/N
Dryness	Y/N
Mouth	
Sores in mouth	Y/N
Dryness	Y/N
Tooth cavities	Y/N
Jaw pain while chewing	Y/N
Nose	
Nose bleeds	Y/N
Throat	
Sore throat	Y/N
Difficulty swallowing	Y/N
Hoarseness	Y/N

Neck	
Swollen glands	Y/N
Tender glands	Y/N
Heart and Lungs	
Chest pain	Y/N
Shortness of breath	Y/N
Cough	Y/N
Wheezing	Y/N
Stomach and Intestines	
Nausea	Y/N
Heartburn	Y/N
Vomiting	Y/N
Abdominal pain	Y/N
Jaundice	Y/N
Diarrhea	Y/N
Black Stools	Y/N
Constipation	Y/N
Kidney/Urine/Bladder	
Pain on urination	Y/N
Blood in urine	Y/N
Cloudy urine	Y/N
Frequent urination	Y/N
Blood	
Anemia	Y/N
Bleeding tendency	Y/N

Skin	
Easy bruising	Y/N
Rash	Y/N
Redness	Y/N
Sun sensitivity	Y/N
Hair loss	Y/N
Hands change color in cold weather	Y/N
Nervous System	
Headaches	Y/N
Dizziness	Y/N
Numbness	Y/N
Where: _____	
Psychiatric	
Depression	Y/N
Excessive worries	Y/N
Women only:	
Number of pregnancies: _____	
Periods: regular / irregular	
Hysterectomy: complete/partial	
Year: _____	
Menopause (Year): _____	
Taken Hormones Y/N	
If yes, when? _____	

Patient Signature: _____ Reviewed by: _____ Date: _____
Date: _____ Reviewed by: _____ Date: _____

Past Medical History

Name: _____ DOB: _____

Do you now or have you ever had: If yes please list when.

High Blood Pressure	Y/N
Diabetes	Y/N
Cancer	Y/N
Heart Disease	Y/N
Ulcers/Reflux/GERD	Y/N
Liver Disease/Hepatitis	Y/N
Kidney Disease	Y/N

Pneumonia/Lung Problems	Y/N
Anemia	Y/N
Depression	Y/N
Thyroid Disease	Y/N
Tuberculosis	Y/N
HIV/AIDS	Y/N
Psoriasis	Y/N

Stroke	Y/N
Seizures	Y/N
Previous Fractures	Y/N

Where: _____

_____

Other: _____

_____

Other significant illness (please list) _____

Please list any prior surgical procedures/hospitalizations:

Type of surgery	Year	Reason
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Medications currently taking (include over the counter):

Name	Start Date	Dosage(MG)	Frequency (How Often)
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____

Allergy List: _____

Family History

Please circle all that apply to your family:

Lupus: Y / N Who? _____

Rheumatoid Arthritis: Y / N Who? _____

Osteoarthritis: Y / N Who? _____

Osteoporosis: Y / N Who? _____

Gout: Y / N Who? _____

Personal History

Type of employment: _____

Where: _____

Do you smoke? Y / N Packs per day? _____

Have you smoked in the past? Y / N

Do you drink alcohol? Y / N

Number of drinks per week: _____

Do you drink caffeinated beverages? Y / N

Cups per day: _____

Illicit/Recreational drug use? Y/N

Live with: _____ City: _____

Number of children: _____ Ages: _____

Patient Signature: _____ Reviewed by: _____ Date: _____

Date: _____ Reviewed by: _____ Date: _____