PATIENT NAME:	AGE:
REFERRING PHYSICIAN	
ADDRESS	
PHONE	EMAIL:

PLEASE CHECK IF YOU HAVE OR HAVE HAD THE FOLLOWING

☐	Autoimmune Disease		☐	Hepatitis		☐	Osteoarthritis
☐	Blood Clots		☐	High Blood Pressure		☐	Osteoporosis
☐	Bowel Disease		☐	High Cholesterol		☐	Peptic Ulcers
☐	Cancer		☐	Kidney Disease		☐	Psoriatic Arthritis
☐	Diabetes		☐	Lung Disease		☐	Rheumatoid Arthritis
☐	Fibromyalgia		☐	Lupus		☐	Skin Disease
☐	Fractures		☐	Miscarriage		☐	Stroke
☐	Gout		☐	Mental Disorder		☐	Thyroid Disease
☐	Heart Disease		☐	Neurological Disease		☐	Urological Disease

PAST SURGERIES - PLEASE LIST TYPE & YEAR

HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS?	Yes		No	
If yes, when?				

SOCIAL HISTORY

Do you use tobacco?	Yes	No	
If yes, packs per day & years of usage			
Do you use alcohol?	Yes	No	
If yes, drinks per day & years of usage			
Do you use Illicit Drugs	Yes	No	
If yes, what is used & years of usage			
Are you married?	Yes	No	
Children & ages?			
What is your occupation?			
Do you have any tattoos?	Yes	No	
Applying for disability?	Yes	No	

FAMILY HISTORY

If any blood relatives have the following diseases, please check & list relationship

		Relationship				Relationship
☐	Rheumatoid Arthritis			☐	Bleeding Disorder	
☐	Osteoarthritis			☐	Osteoporosis	
☐	Lupus			☐	Cancers	
☐	Psoriasis			☐	Mental Disorders	
☐	Gout			☐	Other	

PLEASE LIST ANY ALLERGIES, BOTH ENVIRONMENTAL & MEDICATIONS

PLEASE LIST YOUR CURRENT MEDICATIONS

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING			
☐	Weight Loss	☐	Vomiting
☐	Weight Gain	☐	Abdominal Pain
☐	Increased Appetite	☐	Change in Bowel Habits
☐	Decreased Appetite	☐	Loose Stools
☐	Blurry Vision	☐	Blood in Stool
☐	Hearing Loss	☐	Mucus in Stool
☐	Fatigue	☐	Diarrhea
☐	Insomnia	☐	Constipation
☐	Day-Time Sleepiness	☐	Blood in Urine
☐	Dry Mouth	☐	Frequent Urination
☐	Dry Eyes	☐	Painful Urination
☐	Hair Loss	☐	Numbness or Tingling in Extremities
☐	Oral Ulcers	☐	Muscle Weakness
☐	Nose Bleed	☐	Joint Pain
☐	Headaches	☐	Joint Swelling
☐	Difficulty in Swallowing Solid Foods	☐	Redness of Joints
☐	Difficulty in Swallowing Liquids	☐	Morning Stiffness
☐	Chest Pain	☐	Skin Rash
☐	Shortness of Breath	☐	Sensitivity to Sun Exposure
☐	Nausea	☐	Change in Color of Hands with Cold Exposure

CHECK IF TAKEN & OUTCOME:					
☐	Celebrex		☐	Humira	
☐	Mobic		☐	Remicade	
☐	Prednisone		☐	Rituxan	
☐	Gold Injections		☐	Orencia	
☐	Arava		☐	Actonel	
☐	Plaquenil		☐	Fosamax	
☐	Methotrexate		☐	Miacalcin	
☐	Sulfasalazine		☐	Boniva	
☐	Enbrel		☐	Forteo	