

HEALTH QUESTIONNAIRE

Patient Name: _____ Date Of Birth _____

Reason for visit: _____

Preferred Pharmacy _____ Address _____ City _____ Zip _____

Current medications: Please list **Name** and **Strength**

- | | |
|--------------------|---------------------|
| 1 _____ / _____ mg | 8 _____ / _____ mg |
| 2 _____ / _____ mg | 9 _____ / _____ mg |
| 3 _____ / _____ mg | 10 _____ / _____ mg |
| 4 _____ / _____ mg | 11 _____ / _____ mg |
| 5 _____ / _____ mg | 12 _____ / _____ mg |
| 6 _____ / _____ mg | 13 _____ / _____ mg |
| 7 _____ / _____ mg | 14 _____ / _____ mg |

Medications you have **tried in the past** for your arthritis condition.

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

Allergies: _____

Prior surgeries: _____

Past medical history: Please list any other diseases or illnesses you have now or have had previously.

- | | |
|---------|---------|
| 1 _____ | 4 _____ |
| 2 _____ | 5 _____ |
| 3 _____ | 6 _____ |

Have you ever smoked cigarettes or tobacco in other forms? YES NO If yes, when you were smoking your heaviest, how many packs per day did you smoke on average: _____. What year did you start smoking? _____. If you subsequently quit, what year did you quit? _____.

Do you drink alcohol? YES NO If yes, BEER WINE LIQUOR On average, how many drinks per week? _____. What other physicians care for you; now or in the past?

- | | |
|---------|---------|
| 1 _____ | 3 _____ |
| 2 _____ | 4 _____ |

Is there a history of arthritis or rheumatic disease in your family? Please indicate Father, Mother, or Grandparent.

- | | |
|----------------------------|-----------------|
| Rheumatoid Arthritis _____ | Gout _____ |
| Lupus _____ | Psoriasis _____ |
| Other _____ | |

Is your arthritis problem a result of an accident or trauma? YES NO

* We **DO NOT** provide care for problems related to accidents for which there is ongoing litigation for Workman’s Compensations. Notify the office if you are unclear about your case.

* **Disability forms will NOT be completed until you have received six months of established care from our practice.**