Arthritis Centers of Texas

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Specialists in:

Arthritis	Bursitis
Carpal Tunnel Syndrome	Connective Tissue Disease
Fibromyalgia	Gout
Low Back Pain	Osteoporosis
Tendinitis	Vasculitis

PATIENT HISTORY FORM

Name:_____ Date:_____

Birth Date: _____ Referring Physician:_____

PCP: _____

Prior Rheumatologist? _____

Prior Orthopedist? _____

What is the problem that brought you here?

_____

_____

_____

_____

Health Problems: (Circle)

Hypertension
High Cholesterol
Heart Disease
Stroke

Diabetes
Thyroid Disease

Asthma
Chronic Bronchitis/Empysema
Pneumonia

Liver Disease
Colitis/Crohn's Disease
Ulcers
Gastrointestinal bleeding
GERD/ Reflux/Hiatal Hernia

Glaucoma
Uveitis/Iritis

Anemia
Low white blood cells/platelets
Cancer/Leukemia
Kidney disease
Kidney stones

Tuberculosis
HIV/AIDS

Headaches/Migraines
Depression
Nervous Breakdown
Seizures/Epilepsy

Psoriasis
Sarcoidosis
Rheumatic Fever
Polio

PATIENT HISTORY FORM (cont)

Other Illnesses: (Please List)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT HISTORY FORM (cont)

Hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

When was your last TB test? _____ Never

Have you had a Bone Density Test? Yes / No When? _____

Circle your adult immunizations Influenza vaccine Date _____

Pneumonia vaccine Date _____

Hepatitis B Date _____

Shingles / Varicella vaccine Date _____

Medication Allergies/ Intolerance: (Please list the medicine and reactions)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PATIENT HISTORY FORM (cont)

Social History

Marital status: Single Married Widowed Divorced Partner

Employment: _____

Education: **Grade School** 7 8 9 10 12 **College** 1 2 3 4 **Graduate School**_____

Smoking: No Yes Amount per day _____ Years _____ Quit, when? _____

Alcohol: No Yes Number per week _____
Have you ever felt you had to quit? Yes No

Recreational drug use? No Yes Drugs; _____

Hobbies/Activities:_____ Exercise regularly No Yes _____

Travel History

Have you travelled outside of the US in recent years? Yes / No Where and When?

_____

_____

PATIENT HISTORY FORM (cont)

Family History

Mother: Alive Deceased Age _____
Father: Alive Deceased Age _____
Siblings: Brothers _____ Sisters _____

Please circle items and mark Mother, Father, Brother, Sister as needed

Hypertension
High Cholesterol
Heart Disease
Stroke

Diabetes
Thyroid Disease

Asthma
Chronic Bronchitis/Empysema
Pneumonia

Liver Disease
Colitis/Crohn's Disease
Ulcers
GERD/ Reflux/Hiatal Hernia

Anemia
Cancer/Leukemia

Kidney disease
Kidney stones

Tuberculosis
HIV/AIDS

Headaches/Migraines
Depression
Nervous Breakdown
Seizures/Epilepsy

Glaucoma
Uveitis/Iritis

Psoriasis
Sarcoidosis
Rheumatic Fever

Arthritis/ Rheumatoid
Lupus
Autoimmune disease
List _____
_____
_____

Other Family History

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATION LIST

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____