Hendricks
Rheumatology

Medical Information Form
Please fill out this form and bring to your appointment

PATIENT NAME_____DOB_____

REFERRING PHYSICIAN_____PHONE_____

PRIMARY PHYSICIAN_____PHONE:_____

READING FOR VISIT_____
_____
_____
_____

CURRENT MEDICATIONS (Including Over-The-Counter Meds)

Name	Strength	How often

LIST MEDICATIONS TRIED IN THE PAST FOR THIS PROBLEM

Name	Strength	How often

OTHER TREATMENTS USED (Specify)

(PLEASE CIRCLE) PHYSICIAL THERAPY EXERCISE PROGRAM

JOINT, BURSAL, OR TENDER POINT INJECTIONS (SPECIFY)_____
_____
OTHER_____
_____
_____

PAST MEDICAL HISTORY
Do you or have you ever had:

Diabetes mellitus	Yes	No	Stomach acid or burning medications	Yes	No
Heart condition	Yes	No	Stroke	Yes	No
Lung problem	Yes	No	Color changes of hands with cold weather	Yes	No
High blood pressure	Yes	No	Chest pain	Yes	No
Stomach ulcer	Yes	No	Dry eyes/dry mouth	Yes	No
Mouth or nasal ulcers	Yes	No	Skin tightening/thickening	Yes	No
Rash	Yes	No	Hair loss	Yes	No
Rash or illness after staying out in sun	Yes	No	Eye pain or inflammation	Yes	No
Numbness or weakness	Yes	No	Lost babies	Yes	No
Abdominal pain, cramps	Yes	No	Blood clots anywhere	Yes	No
Rectal bleeding/ diarrhea/constipation	Yes	No	Heart valve problems	Yes	No
Migraines, spotty visual loss	Yes	No	Mottled skin	Yes	No
Loss of memory or thinking	Yes	No	Chronic sinus problems	Yes	No

Other:_____
_____

PAST SURGICAL HISTORY

ORTHOPEDIC SURGERY OR ARTIFICIAL JOINTS (Specify)_____

OTHER (Specify)_____
_____

OTHER HOSPITALIZATIONS
(other than the surgery above)

Date	Reason
_____	_____
_____	_____
_____	_____

PAST INJURIES / ACCIDENTS / BROKEN BONES
_____
_____
_____
_____

DRUG ALLERGIES OR SENSITIVITIES
(Specify)

DRUG	REASON
_____	_____
_____	_____
_____	_____

BLOOD TRANSFUSIONS
YES NO DATES _____ _____ _____ _____

HABITS
(please circle)
CURRENTLY SMOKE? Yes No cigarettes cigars pipe
Have you smokes any of the above in the past? Yes No
Year started _____ Year stopped_____ Packs/day_____

CURRENTLY DRINK? Yes No Regular Basis Rarely

USED TO DRINK Yes No Regular Basis Rarely

FAMILY MEDICAL HISTORY
For the following please list the age they are (or were) as well as any health problems they have or had (include reason for death)
Father_____
Mother_____
Brother/Sister_____
Brother/Sister_____
Brother/Sister_____

WHO IN YOUR FAMILY HAS ANY OF THE FOLLOWING:
DIABETES_____
EARLY HEART ATTACKS (BEFORE AGE 60)_____
HIGH BLOOD PRESSURE_____
THYROID DISEASE_____
BREAST CANCER_____
OSTEOPOROSIS_____

LIVING SITUATION
Married Single Single with other(s) in same house

ACTIVITIES
Are you able to do your own routine self-care, household, or yard chores? (specify)
Yes No Explain_____

EXERCISE AND HOBBIES
Aerobic Yes No Frequency_____
Weight lifting Yes No Frequency_____
Hobbies Yes No Frequency_____

MY LAST PHYSICAL EXAMINATION
Was done on (date):_____
Physician:_____ Phone:_____

ADDITIONAL INFORMATION YOU WISH US TO KNOW (specify):_____
_____.
_____.
_____.

Dates of Last Vaccine for:
Influenza _____ Pneumonia _____ Tetanus_____

****FOR WOMEN ONLY****
My last pelvic exam and Pap smear was done (date) _____/_____/_____
My last breast exam was done _____/_____/_____ My last Mammogram was _____/_____/_____

I have always used milk and dairy products Yes No
How old were you at menopause?_____

Have you had:

Hysterectomy	Yes	No	Date_____
Ovaries removed	Yes	No	Date_____
Early pregnancy loss (less than 12 weeks)	Yes	No	Date_____
Later pregnancy loss (more than 12 weeks) Specify:_____	Yes	No	Date_____
Problems with birth control pills or estrogen	Yes	No	Date_____

Total number of pregnancies:_____

****FOR MEN ONLY****

My last prostate/testicles/PSA test: _____/_____/_____
Physician Name:_____ Phone:_____

Signature Date