ARTHRITIS & RHEUMATIC CARE CENTER

Jaime A. Pachon, M.D. Margarita R. Garces, M.D. Olga Kromo, M.D. Patricia M. Mueller, M.D.

Name_____Age_____Date_____

Referred by_____

MEDICAL ILLNESSES (Check if you have had any of the following illnesses, and list any additional medical conditions)

- ☐ Arthritis
- ☐ Cancer (what organ?_____)
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease, Hepatitis
- ☐ Lung Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcer of Stomach/Duodenum
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

HOSPITALIZATIONS & SURGERIES (List illnesses & operations with approximate dates)

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY (**List illnesses.** If deceased, note age and cause of death.)

Father _____

Mother _____

Brothers/Sisters_____

_____

_____

Children_____ Total # of children _____

_____ Ages_____

SOCIAL HISTORY - Please Circle

Do you smoke? Yes No If yes, how much_____

Do you drink alcohol? Yes No If yes, how much_____

Marital Status: - Please circle below:

Single Married Widowed Divorced

MEDICINES YOU ARE TAKING
(including birth control pills, vitamins & nonprescription supplements)

1_____ 4_____ 7_____

2_____ 5_____ 8_____

3_____ 6_____ 9_____

MEDICINE ALLERGIES
(list medications and type of reaction)

_____ _____

_____ _____

_____ _____

(OVER)

ARTHRITIS & RHEUMATIC CARE CENTER

Jaime A. Pachon, M.D. Margarita R. Garces, M.D. Olga Kromo, M.D. Patricia M. Mueller, M.D.

Name_____Date_____

SYSTEMS REVIEW Do you now or have you recently had any of the following problems? Circle **Y** or **N**.
Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Weight loss Y N
- Fatigue/Tired Y N
- Other_____

Eyes
- Changes in vision Y N
- Eye Pain Y N
- Dry Eyes Y N
- Other_____

Neurological
- Headache Y N
- Muscle weakness Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Weight gain Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Diarrhea Y N
- Indigestion/heartburn Y N
- Other_____

Skin
- Skin rash Y N
- Hair loss Y N
- Sun sensitivity Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Joint swelling Y N
- Joint stiffness Y N
- Other_____

Ear/Nose/Throat/Mouth
- Oral ulcers Y N
- Dry mouth Y N
- Difficulty swallowing Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Palpitations Y N
- Other_____

Genitourinary
- Painful urination Y N
- Urinary frequency Y N
- Blood in Urine Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Leg swelling Y N
- Other_____

Psychologic
- Do you feel severely depressed? Y N
- Are you nervous/anxious? Y N
- Sleep disturbance? Y N
- Other_____

Explain _____

_____

FOR OFFICE USE ONLY:

Physician Signature:_____ Date:_____/_____/_____