ARTHRITIS & RHEUMATIC CARE CENTER

Jaime A. Pachon, M.D. Margarita R. Garces, 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)

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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:_____/_____/_____