

HEALTH QUESTIONNAIRE

Patient Name: _____ Date _____

1) Reason for visit: _____

2) Referring physician: _____ Phone number _____

3) Current medications that you use to treat your arthritis. (Bring a list of all other Medications)

1) _____	4) _____
2) _____	5) _____
3) _____	6) _____

4) Medications you have tried in the past for your arthritis condition. Continue on another sheet if necessary.

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

5) Allergies: _____

6) Prior surgeries: _____

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

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

8) 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
average: _____ packs
What year did you start smoking? _____
If you subsequently quit, what year did you quit? _____

9) Do you drink alcohol: yes no
If yes, beer wine liquor
On average, how many drinks per week? _____

10) What other physicians care for you; now or in the past?

1) _____ 3) _____
2) _____ 4) _____

11) Is there a history of arthritis or rheumatic disease in your family? If so, indicate which family members.

Rheumatoid Arthritis _____ Gout _____
Lupus _____ Psoriasis _____
Other _____

12) Is your arthritis problem a result of an accident or trauma? yes no

Realize we don't provide care for problems related to accidents for which there is ongoing litigation or for Workman's Compensation. Notify the office if you are unclear about your case.

13) Please check the symptoms you are having:

Arthritis	Heartburn or reflux
Skin rashes	Difficulty swallowing
Psoriasis	Stomach ulcers
Hair loss	Diarrhea
Eye symptom	Constipation
Dry eyes	Irregular bowels
Sinus problems	Liver disease
Ear problems	Kidney disease
Sore throat	Bladder infection
Dry mouth	Numbness of hands/feet
Ulcers in the mouth or nose	Carpal tunnel syndrome
Genital ulcers	Headaches
Persistent lymph node swelling	Muscular weakness
Coughing	Color changes of hands
Shortness of breath	Puffy tight hands
Chest pain	Fatigue
Fever/chills	Difficulty sleeping
Night sweats	Depression/bipolar
Weight loss	Anxiety
Abdominal pain	Other psychiatric disease