Low Country Rheumatology, A Member of Articularis Healthcare, Inc.
Health Questionnaire

Patient Name: _____ Date of Birth: _____

Reason for visit:_____

Preferred Pharmacy: _____ Address: _____

City: _____ State: _____ Zip: _____

Current medications: Please list **name** and **strength**.

1 _____/_____mg
2 _____/_____mg
3 _____/_____mg
4 _____/_____mg
5 _____/_____mg
6 _____/_____mg
7 _____/_____mg
8 _____/_____mg
9 _____/_____mg
10 _____/_____mg
11 _____/_____mg
12 _____/_____mg
13 _____/_____mg
14 _____/_____mg

Medications you have **tried in the past** for your arthritis condition.

1 _____ 3 _____
2 _____ 4 _____

Medical History: Please list any diseases or illnesses you have now or have had previously.

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

Medication or Latex allergies: _____

Prior Surgeries: _____

_____

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 smoke, on average: _____

What year did you start smoking? _____ If you subsequently quit, what year did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, please circle: Beer Wine Liquor

On average, how many drinks per week? _____

What other physicians care for you, now and in the past?

1._____ 3._____
2._____ 4._____

Please indicate the history of arthritis or rheumatic disease in your family:

	Father	Mother	Sibling
Rheumatoid Arthritis			
Gout			
Psoriasis			
Lupus			
Other:			

Is your arthritis a result of an accident or trauma? ☐ Yes ☐ No

*We **do not** provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensation. Notify the office if you are unclear about your case.

*Disability forms **will not** be completed until you have received six months of established care from our practice.