MEDICAL HISTORY FORM

DATE_____

PATIENT'S NAME_____ AGE_____ DATE OF BIRTH_____

EXPLAIN BRIEFLY WHAT SYMPTOMS BRING YOU TO THIS OFFICE:

ARE ANY OF YOUR PRESENT PROBLEMS DUE TO INJURY? Yes____, No____

Industrial?_____

ARE YOU RIGHT-HANDED [ ] OR LEFT-HANDED [ ]?

PAST MEDICAL HISTORY:

1. HAVE YOU EVER HAD: (Check the appropriate boxes and list year to the right)

[ ] Measles
[ ] German Measles
[ ] Chickenpox
[ ] Mumps
[ ] Diphtheria
[ ] Rheumatic Fever
[ ] Polio
[ ] Meningitis
[ ] Tuberculosis (or positive test)
[ ] Valley Fever (or positive test)
[ ] Malaria
[ ] Parasites
[ ] Syphilis (or positive test)
[ ] Gonorrhea
[ ] AIDS, ARC (or positive test)
[ ] Genital Herpes
[ ] Lyme Disease

[ ] High blood pressu
[ ] Angina Pectoris
[ ] Heart Attack
[ ] Stroke
[ ] Pericarditis
[ ] Heart Murmurs
[ ] High Cholesterol
[ ] High Triglycerides
[ ] Cancer
[ ] Nephritis
[ ] Kidney Stones
[ ] Diabetes
[ ] Thyroid Disease
[ ] Gout
[ ] High Uric Acid
[ ] Gastric Ulcer
[ ] Duodenal Ulcer
[ ] Bleeding Ulcer
[ ] Anemia

[ ] Pancreatitis
[ ] Ulcerative Colitis
[ ] Crohn's Disease
[ ] Sarcoidosis
[ ] Osteoporosis
[ ] Paget's Disease
[ ] Hepatitis
[ ] Cirrhosis
[ ] Gallbladder Problems
[ ] Epilepsy
[ ] Pneumonia
[ ] Pleurisy
[ ] Asthma
[ ] Hay Fever
[ ] Chronic Bronchitis
[ ] Emphysema
[ ] Psychiatric Illness
[ ] Alcoholism
[ ] Drug Addiction

2. PLEASE LIST IN CHRONOLOGICAL ORDER ALL HOSPITALIZATIONS, SERIOUS ILLNESSES, OPERATIONS, SEVERE INJURIES, AND BROKEN BONES.

CONDITION OR OPERATION	DATE	HOSPITAL	CITY	STATE	DOCTOR

Attach a separate page for this if needed.

3. PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

(Please bring your medications with you to your office visit.)

MEDICATION	DOSE	FREQUENCY

MEDICATION	DOSE	FREQUENCY

Attach a separate page for this if needed.

4. HAVE YOU EVER TAKEN?: (Please check the appropriate boxes)

[ ] Injected Biological Drugs _____ for Arthritis or related diseases
[ ] ACTH (injection)
[ ] Allopurinol (zyloprim)
[ ] Anturane. (sulfinpyrazone)
[ ] Azulfidine (sulfasalazine)
[ ] Benemid (probenecid)
[ ] Clinoril (sulindac)
[ ] Colchicine or Colbenemid
[ ] Cortisone - By Mouth___, By Injection___
[ ] Cytoxan (cyclophosphamide)
[ ] Feldene (piroxicam)
[ ] Gold – Ridaura, By Mouth , ___ or Myochrysine or Solganol, By Injection,___
[ ] Imuran (azathioprine)
[ ] Indocin (indomethacin
[ ] Lodine (etodolac)
[ ] Motrin (ibuprofen)
[ ] Meclomen (meclophenamate)
[ ] Naprosyn (naproxen)
[ ] Penicillamine (cuprimine)
[ ] Plaquenil (hydroxychloroquine)
[ ] Rheumatrex (methotrexate)
[ ] Tolectin (tolmetin).
[ ] Other Arthritis Medications?_____

5. PLEASE LIST ALL MEDICATIONS THAT YOU DO NOT TOLERATE OR ALLERGIC TO:

MEDICATION	TYPE OF REACTION

MEDICATION	TYPE OF REACTION

6. PLEASE LIST ALLERGIES OTHER THAN DRUG RELATED:

_____

7. HAVE YOU RECENTLY RECEIVED PHYSICAL THERAPY?

[ ] Hot packs
[ ] Cold packs
[ ] Paraffin
[ ] Whirlpool
[ ] Exercises
[ ] Massage
[ ] Traction
[ ] Electrotherapy
[ ] Splints
[ ] Canes, Braces
[ ] Crutches
[ ] Cervical Collar or Cervical Pillow

8. WHEN WERE YOU LAST IMMUNIZED AGAINST:

[ ] German Measles, [ ] Tetanus, [ ] Influenza, [ ] Pneumococcus, [ ] Hepatitis B

9. MARITAL HISTORY:

Your present status:_____How Long?_____

Spouse: Occupation_____ Health_____Age_____

Are you satisfied with your present marital status? _____

10. SOCIAL HISTORY:

Work: Hours per week _____Occupation_____

Have you missed work due to this illness or injury? Yes__ No __. If Yes, please explain _____

_____

Date last worked: _____

Date returned to part-time work:_____

Date returned to full-time work: _____

Birthplace: _____Your Ethnic Origin _____

How long have you been in Santa Clara County? _____

With whom do you live? _____

Do you exercise regularly?_____

Do you follow a special diet? _____

How much tobacco per day? _____

Alcohol: Daily___, Occasionally___, Rarely___ Never___.

11. FAMILY HISTORY: (Please list each member separately)

RELATIVE	AGE	HEALTH if living	IF DECEASED, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				
DAUGHTERS				
SONS				

HAS ANY BLOOD RELATIVE HAD: (Please list who)

[ ] Rheumatoid Arthritis
[ ] Spondylitis (spine inflammation)
[ ] Osteoarthritis (degenerative arthritis)
[ ] Lupus Erythematosus
[ ] Polyarteritis,
[ ] Dermatomyositis,
[ ] Polymyositis
[ ] Scleroderma,
[ ] Raynaud's Disease
[ ] Psoriasis
[ ] Osteoporosis
[ ] Hip or Spine Fractures
[ ] Gout
[ ] Glaucoma (increased eye pressure)
[ ] Kidney Stones
[ ] Diabetes
[ ] Stomach Ulcers
[ ] Heart Disease
[ ] High Blood Pressure
[ ] TB
[ ] Cancer
[ ] Birth Defects
[ ] Stroke
[ ] Blood Disorders
[ ] Alcoholism
[ ] Drug Addiction

12. ARE YOU NOW TROUBLED WITH:

MUSCULOS KELETAL SYMPTOMS:	[ ] Swollen Joints - where?_____ [ ] Painful Joints - where?_____ [ ] Morning Stiffness - where? _____ How Long (Hours before improvement)?_____ [ ] Neck Pain [ ] Upper Back Pain [ ] Lower Back Pain [ ] Heel Pain [ ] Muscle Pain [ ] Muscle Weakness
SKIN:	[ ] Rash [ ] Psoriasis [ ] Lumps or Nodules [ ] Skin Sensitivity to Sunlight [ ] Change in Skin Texture, Color, or Moisture [ ] Easy Bruising or Bleeding [ ] Skin Ulcers [ ] Abnormal Hair Loss [ ] Fingers Turning While on Exposure to Cold
GASTROINTESTINAL SYMPTOMS:	[ ] Heartburn [ ] Nausea [ ] Vomiting [ ] Vomiting Blood [ ] Abdominal Pain [ ] Constipation [ ] Diarrhea [ ] Yellow Jaundice [ ] Recent Change in Bowel Habits [ ] Stools Which Are ( )Black; ( )Bloody
GENERAL SYMPTOMS	[ ] Dizziness [ ] Fever [ ] Shaking Chills [ ] Excessive or Unusual Fatigue [ ] Recurrent Infections [ ] Swollen Glands [ ] Glaucoma (increased eye pressure) [ ] Kidney Stones [ ] Diabetes [ ] TB [ ] Cancer [ ] Birth Defects [ ] Stroke [ ] Blood Disorders [ ] Alcoholism, [ ] Drug Addiction
EYES:	[ ] Impaired or Changing Vision [ ] Double Vision [ ] Persistent Dry Eyes [ ] Eye Inflammation [ ] Glaucoma [ ] Cataracts [ ] Glasses [ ] Do you use artificial tears?

EARS:	[ ] Deafness [ ] Ringing in Ears [ ] Hearing Aid
NOSE:	[ ] Sinus Trouble - Type_____ [ ] Nose Bleeds
MOUTH, THROAT:	[ ] Mouth Ulcers [ ] Persistent Dry Mouth [ ] Hoarseness [ ] Sore Throats [ ] Jaw Pain With Chewing [ ] Difficulty Swallowing
CARDIOVASCULAR and RESPIRATORY:	[ ] Shortness of Breath [ ] Chest Pain [ ] Cough [ ] Coughing Up Blood [ ] Leg Swelling [ ] Palpitations
GENITOURINARY:	[ ] Urinary Tract Infections [ ] Frequency of Urination ( )Times per day, ( )Times per night [ ] Burning with Urination [ ] Blood in Urine [ ] Urgency of Urination [ ] Discharge From the Penis [ ] Excessive Vaginal Discharge [ ] Difficulty Starting ___ or Stopping ___ Flow of Urine [ ] Rash or Sores on Genitals
METABOLIC:	[ ] Unusual Heat Intolerance [ ] Unusual Cold Intolerance [ ] Excessive Thirst [ ] Excessive Urination [ ] Excessive Appetite [ ] Loss of Appetite [ ] Weight Loss or Gain, Since When?_____ [ ] Hot Flashes
NEUROLOGIC:	[ ] Headaches: ( )Migraine, ( )Sinus, ( )Tension [ ] Numbness, Burning, or Tingling - Where? [ ] Loss of Memory [ ] Loss of Consciousness [ ] Nervousness [ ] Depression [ ] Suicidal Ideas [ ] Difficulty Sleeping [ ] Any Other Medical Problems or Symptoms?
MENSTRUAL HISTORY:	Age at Onset _____ Duration of Flow_____ Days Between Periods_____ Symptoms with Periods _____ First Day of Last Period _____ Number of Pregnancies_____ Number of Children _____

Please bring with you the names and addresses where pertinent medical records, laboratory tests, and x-rays might be obtained. We can then request what records we need. Thank You.