Florida Medical Clinic Rheumatology
Your life. Our specialty.

## DRUG ALLERGIES

Please list medication and reaction:

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

## CURRENT MEDICATIONS

Please list all medications you are currently taking:

Name:_____ Dose:_____ Reason:_____ How often:_____
Name:_____ Dose:_____ Reason:_____ How often:_____
Name:_____ Dose:_____ Reason:_____ How often:_____
Name:_____ Dose:_____ Reason:_____ How often:_____
Name:_____ Dose:_____ Reason:_____ How often:_____
Name:_____ Dose:_____ Reason:_____ How often:_____

## PATIENT OVERVIEW

Name:_____

Out of Town Address:_____

Referred by:_____

Primary Care Physician Name:_____

Briefly describe present symptoms:

Date symptoms began:_____

Previous treatments for this problem:

Names of other physicians seen for above symptoms:

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## FAMILY HISTORY

Father: Alive ◯ Deceased ◯ Cause of death:_____

Mother: Alive ◯ Deceased ◯ Cause of death:_____

## HOSPITALIZATIONS

Have you had any fractures? No ◯ Yes ◯ If yes, explain:_____

Date:_____ Reason:_____ Where:_____

Date:_____ Reason:_____ Where:_____

Date:_____ Reason:_____ Where:_____

Date:_____ Reason:_____ Where:_____

## PROCEDURES

When was the last time you had the following tests:

Rectal Exam: _____ Pelvic/Pap: _____

Sigmoid/Colonoscopy: _____ Mammogram: _____

Blood in Stool: _____ TB Skin Test: _____

Chest X-ray: _____ EKG: _____

## SOCIAL HISTORY

Married ◯ Never Married ◯ Divorced ◯ Separated ◯ Widowed ◯

Obstetric History:

Number of pregnancies: _____ Premature births: _____ Miscarriages/abortions:_____

Number of living children:_____ Grandchildren: _____ Great-grandchildren: _____

Current occupation:_____

Social Habits:

Smoker ◯ Nonsmoker ◯ If so, how much?_____ How long?_____

Have you quit? No ◯ Yes ◯ If so, when? _____

Do you drink alcohol? No ◯ Yes ◯ If so, how much? _____ How long?_____

Do you consume (please check) Milk ☐ Cheese ☐ Yogurt ☐ Cottage Cheese ☐ If so, how much per day?_____

Do you take calcium: No ◯ Yes ◯ If so, how much?_____

Do you wear a seatbelt? No ◯ Yes ◯

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# PERSONAL HISTORY & HEALTH ASSESSMENT

DATE:_____

NAME:_____ DOB:_____

## PAST MEDICAL & FAMILY HISTORY

Please check if your or any indicated family members have had the following conditions:

| Condition | Yourself | Mother | Father | Brother | Sister |
|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ankylosing Spondylitis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Atherosclerosis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Coronary Artery Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cataracts | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colitis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gout | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ischemic Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hyperlipidemia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lupus or SLE | ☐ | ☐ | ☐ | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Renal Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ |