PATIENT MEDICAL INFORMATION

Patient Name _____

Date of Birth _____

Family History

Please list the relationship to you of "Blood Relatives" who have had the following diseases.

Diabetes _____ Arthritis _____

Rheumatoid Arthritis _____ Cancer _____

High Blood Pressure _____ Lupus _____

Heart Disease _____ Gout _____

Kidney Disease _____ Other _____

Thyroid Disease _____ Psoriasis _____

Osteoporosis _____

Social History

Marital Status _____ # of Children _____

Hobbies or Interests _____

Last grade of school completed _____

Describe occupation _____

Sources of unusual stress _____

# of cigarettes smoked per day _____ # of alcoholic drinks per day _____ # cups of coffee per day _____

Do you or have you ever used recreational drugs? _____

What is your exercise program? _____

How many days/week do you exercise? _____

Activities of Daily Living

List daily activities with which you have trouble because of your arthritis or muscle pain (eg: combing hair, bathing, kitchen activities, yard work, etc.) _____

_____

_____

**Please list the physician who should get copies of your office visits:

Doctor: _____ Address: _____

Doctor: _____ Address: _____