# CHS Rheumatology Care
# PAST HISTORY

**DATE** _____/_____/_____

**NAME**_____

**AGE**_____ **DOB**_____ **SEX M / F** **RACE**_____

**PAST MEDICAL HISTORY** (Check if "yes")

____ High Blood Pressure
____ Heart Disease
____ High Cholesterol
____ Diabetes Mellitus
____ Thyroid Disease
____ Cancer
____ Anemia
____ Blood Transfusion
____ Blood Clots
____ Sinusitis
____ Asthma
____ Rheumatoid Arthritis
____ Lupus
____ Emphysema/COPD
____ Pneumonia
____ Acid Reflux/GERD
____ Stomach Ulcer
____ Irritable Bowel Syndrome
____ Crohn's/Ulcerative colitis
____ Hepatitis/Liver Disease
____ Migraine Headache
____ Epilepsy/Seizure Disorder
____ Stroke/TIA
____ Nerve Disease/Neuropathy
____ Gout
____ Osteoarthritis
____ Psoriasis
____ Iritis/Scleritis
____ Dry Eyes
____ Raynaud's Phenomenon
____ Muscle Disease
____ Broken Bone(s)
____ Kidney Disease
____ Kidney Stone
____ Psychiatric Illness
____ Sexually Transmitted Disease
____ Drug or Alcohol abuse
____ Fibromyalgia
____ Osteoporosis

**HOSPITALIZATIONS / OPERATIONS** ☐ **No Surgery / Hospitalization**

| | Year |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |

**CURRENT MEDICATIONS** (Name, Dosage) ☐ **No Current Meds**

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____



(Continued on back)

## DRUG ALLERGIES

☐ No Drug Allergies

## FAMILY HISTORY

| | Age | Joint diseases /Major Medical Conditions |
|---|---|---|
| Mother | ____ | _____ |
| Father | ____ | _____ |
| Sister | ____ | _____ |
| Sister | ____ | _____ |
| Brother | ____ | _____ |
| Brother | ____ | _____ |
| Other | ____ | _____ |
| Other | ____ | _____ |

## SOCIAL HISTORY

Occupation _____ Highest level of Education _____

Marital Status (circle one) Never Married Married Divorced Separated Widow(er) Number of children_____

Do you use any Tobacco product? No Yes _____ Do you drink Alcohol? No Yes_____

On Disability? No Yes Year _____ Applied for Disability? No Yes

Sleep Very Poor Poor Satisfactory Good _____

Treatment for Depression/Anxiety Never Past Current _____

Regular Physical Exercise? How Often? _____

## NOTES / ADDITIONAL HISTORY