COMMUNITY CARE RHEUMATOLOGY
OF COMMUNITY CARE PHYSICIANS, P.C.

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MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint/Reason for visit: _____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: ex: Folic Acid	**Dosage:** ex: 1mg	**Instructions:** ex: 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction:** ex: Nausea

Past Medical History: Please check if you or **your immediate family** have a history of any condition below:

	self	family member		self	family member
Alcoholism	☐	☐ _____	Kidney Disease	☐	☐ _____
Anemia	☐	☐ _____	Liver Disease	☐	☐ _____
Autoimmuue Disorder	☐	☐ _____	Lupus	☐	☐ _____
Cancer	☐	☐ _____	Lung Problems	☐	☐ _____
Congestive Heart Failure	☐	☐ _____	Osteoarthritis	☐	☐ _____
Colitis	☐	☐ _____	Osteoporosis	☐	☐ _____
COPD	☐	☐ _____	Psoriasis	☐	☐ _____
Crohn's Disease	☐	☐ _____	Prostate	☐	☐ _____
Depression	☐	☐ _____	Rheumatoid Arthritis	☐	☐ _____
Diabetes	☐	☐ _____	Scleroderma	☐	☐ _____
GERD	☐	☐ _____	Seizures	☐	☐ _____
Gout	☐	☐ _____	Sexually Transmitted Disease	☐	☐ _____
Glaucoma	☐	☐ _____	Stomach Ulcers	☐	☐ _____
Heart Disease	☐	☐ _____	Stroke	☐	☐ _____
High Cholesterol	☐	☐ _____	Thyroid Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____	Tuberculosis	☐	☐ _____
Hepatitis	☐	☐ _____	Pulmonary Hypertension	☐	☐ _____

Other Major Illnesses: _____

_____

Surgical History: Please list all past operations with dates.

_____

_____

_____

_____

Social History:

Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) ☐ Male ☐ Female

Marital Status: (select one) ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:_____

Race: (select one)
☐ Caucasian ☐ African American ☐ Asian ☐ Native American
☐ Native Alaskan ☐ Native Hawaiian ☐ Pacific Islander ☐ Declined

Ethnicity: (select one) ☐ Hispanic ☐ Non–Hispanic ☐ Declined

Primary Language: (select one) ☐ English ☐ French ☐ Spanish ☐ Other:_____

Occupation:_____ Number of Children:_____
Number of Pregnancies:_____ Number of Miscarriages:_____

Tobacco Use:
☐ Never smoked
☐ Currently smoke every day: Number of packs per day: _____
☐ Currently smoke some days
☐ I have quit smoking: Age when stopped: _____

Alcohol Use:
How many days per week do you drink? _____ How drinks per day? _____
Have you ever had a problem with alcohol? ☐ Yes ☐ No

Illicit / Recreational Drug Use:
Do you use drugs? ☐ Yes ☐ No How often? _____
Have you ever had a problem with illicit drug use? ☐ Yes ☐ No

Exercise:
☐ Yes: How often? _____ ☐ No

Contacts:

Pharmacy:
Retail:_____ Address/Phone:_____
Retail:_____ Address/Phone:_____
Mail order:_____ Address:_____

Names of Physicians/Other Specialists which are treating you:
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____

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Name: _____

DOB: _____

Reason for your visit today:

_____

In the past month, have you experienced any of the following? Check box if yes.

□ Weight change
□ Chills
□ Fever
□ Night sweats
□ Feeling tired or poorly
□ Headache
□ Facial pain
□ Sinus pain
□ Head-related symptoms
□ Easy bleeding
□ Easy bruising
□ Neck pain
□ Lump or swelling in the neck
□ Breast pain
□ Nipple discharge
□ Breast lump
□ Chest pain
□ Pounding heartbeat
□ Palpitations
□ Rash
□ Skin lesion
□ Itching
□ White or purple discoloration of finger or toes
□ Pain during urination
□ Urinary frequency
□ Blood in urine
□ Genital lesion
□ Vaginal discharge
□ Pain during intercourse
□ Incontinence
□ Excessive sweating
□ Excessive thirst
□ Hot flashes
□ Decrease in height
□ Vision problems
□ Eye sensitivity
□ Sinus pain
□ Eyes itch
□ Earache
□ Loss of hearing
□ Ringing in ears
□ Nosebleeds
□ Nasal discharge
□ Mouth sores
□ Bleeding gums
□ Hoarseness
□ Sore throat
□ Shortness of breath
□ Cough
□ Wheezing
□ Poor appetite
□ Difficulty swallowing
□ Heartburn
□ Nausea
□ Vomiting
□ Abdominal pain
□ Diarrhea
□ Black or tarry stools
□ Constipation
□ Joint pain
□ Joint stiffness
□ Joint swelling
□ Muscle aches
□ Back pain
□ Muscle weakness
□ Dizziness
□ Fainting
□ Motor disturbances
□ Sensory disturbances
□ Sleep disturbance
□ Anxiety
□ Depression

Since your last visit have you experienced or developed any of the following?

- Infection? If so which type and did you receive antibiotics? _____
- Allergy? To what and what was the reaction? _____
- Were diagnosed with a new medical condition? _____
- Did you have any surgery? Who was your surgeon? _____
- Were you prescribed any new medications? _____