TMH PHYSICIAN PARTNERS

TMH PHYSICIAN PARTNERS SOUTHWOOD
RHEUMATOLOGY SPECIALIST
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ **Today's Date:** _______________________

Date of Birth: ________________**Age:** _____ **Sex: [ ] M [ ] F** **Height:** _________ **Weight:** _______

Reason for visit?____

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-stroke)
[ ] Epilepsy
[ ] Ulcerative Colitis/Crohn's
[ ] Heart Disease
[ ] Diabetes
[ ] Cataracts
[ ] Pneumonia
[ ] Emphysema (COPD)
[ ] Gastric Reflux
[ ] Liver Problems
[ ] Kidney Problems/Failure
[ ] Hepatitis
[ ] Thyroid Problems
[ ] Seizure Disorder
[ ] Stomach Ulcers
[ ] Sleep Disorder
[ ] Prostate Problems
[ ] HIV/AIDS
[ ] Other: ____________________

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Have you had any of the following? Have any immediate relatives had any of the following (mother, father, siblings, children)?

Psoriasis [ ] No [ ] Yes _______________________________________
Osteoarthristis [ ] No [ ] Yes _______________________________________
Gout [ ] No [ ] Yes _______________________________________
Juvenile Arthritis [ ] No [ ] Yes _______________________________________
Lupus of "SLE" [ ] No [ ] Yes _______________________________________
Rheumatoid Arthritis [ ] No [ ] Yes _______________________________________
Ankylosing Spondylitis [ ] No [ ] Yes _______________________________________
Osteoporosis [ ] No [ ] Yes _______________________________________
Others (Sjorgen's, Scleroderma, etc..) [ ] No [ ] Yes _______________________________________

Are you current on the Flu vaccine? [ ] No [ ] Yes; if yes when did you last have the flu vaccine?________________

Have you had the Pneumonia vaccine? [ ] No [ ] Yes

Have you had the Shingle vaccine? [ ] No [ ] Yes

Do you exercise regularly? [ ] No [ ] Yes; if yes, how many times per week? _______________________

How many hours of sleep do you typically get? _____ Do you fell well rested? [ ] No [ ] Yes

Do you have trouble falling asleep or staying asleep? [ ] No [ ] Yes

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Do you smoke? [ ]No [ ]Yes; if yes, packs /day: _________Year Quit: __________

Do you drink alcohol? [ ]No [ ]Yes; if Yes, drinks per day _____ Per week: _______

Do you use recreational drugs? [ ]No [ ]Yes; if yes, describe: ____

Have you lost interest in doing things that use to give you pleasure?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you been feeling down, depressed or hopeless in the past 2 weeks?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you experienced 10 lbs weight loss or weight gain in the past 3 months? [ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)? [ ]No [ ] Yes; if yes, please describe the problem and/or the device used.____

Have you had a fall in the past year? [ ] No [ ] Yes Do you feel unsteady? [ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt? [ ] No [ ] Yes

Please see separate medication list; please complete to the best of your ability.

Are you allergic to any medications? [ ] No [ ] Yes; if yes please list the medication(s) and your reaction to it:

____

____

Are you allergic to any other foods or substances? [ ] No [ ] Yes; if yes, please list the item(s):

____

Preferred Pharmacy: ________________________________ Location: ______________________________________