Buckhead Rheumatology

Medical History

Full name: _____ Date of birth: _____ Date: _____

Primary Doctor: _____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty: _____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, include non-prescription, supplements, herbs, birth control)

_____

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ❑ Alcohol/Drug addiction
- ❑ Anemia
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Blood Transfusion
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Gerd
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart murmur
- ❑ Hepatitis B or C
- ❑ High cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Seizure
- ❑ Sickle cell disease
- ❑ Sjogren's Syndrome
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcerative colitis
- ❑ Other: _____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Mother				
Father				
Brothers and Sisters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			
Sons and Daughters	1) ❑ M ❑ F			
	2) ❑ M ❑ F			
	3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years? _____

Are you a former smoker? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit? _____

Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:

_____

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?

Advanced Directive for Healthcare

Review of symptoms (please check if you have recently had the following symptoms):

- ❑ Weight gain
- ❑ Weight loss
- ❑ Night sweats
- ❑ Weakness
- ❑ Fatigue
- ❑ Insomnia
- ❑ Change in vision
- ❑ Fever
- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Chest pain
- ❑ Palpitations
- ❑ Fainting
- ❑ Difficulty swallowing
- ❑ Indigestion or heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Joint Pain (location)
  - ❑ Hand ❑ Wrist
  - ❑ Back ❑ Neck
  - ❑ Elbow ❑ Shoulder
  - ❑ Hip ❑ Knee
  - ❑ Ankle ❑ Foot

  _____
- ❑ Blood in stool
- ❑ Frequency of urination
- ❑ Dry Eyes
- ❑ Dry Mouth
- ❑ Abnormal Lab
- ❑ Anxiety
- ❑ Depression
- ❑ Feeling too hot
- ❑ Feeling too cold
- ❑ Dizziness
- ❑
- ❑ Headaches
- ❑ Memory loss
- ❑ Numbness/Tingling
  - ❑ Hand ❑ Wrist
  - ❑ Back ❑ Neck
  - ❑ Elbow ❑ Shoulder
  - ❑ Hip ❑ Knee
  - ❑ Ankle ❑ Foot
- ❑ Skin Rash
- ❑ Other: _____

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

_____ _____ _____ _____

Patient/Designee Signature | Patient Name (Print) | Date (MM/DD/YY) | Time

_____ _____

Relationship to Patient | Reason Patient is Unable to Sign