ORTHOPEDIC PHYSICIANS ALASKA
OrthoAlaska LLC

NEW PATIENT
RHEUMATOLOGIC HEALTH HISTORY

Name_____ Date of Birth _____/_____/_____Today's Date _____/_____/_____

CURRENT MEDICATIONS AND DOSAGE (may attach separate sheet if available)

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

MEDICATION ALLERGIES (AND REACTIONS): _____

MEDICAL HISTORY (circle)

Anemia	Yes	No	Gout	Yes	No	Lupus	Yes	No
Arthritis	Yes	No	Heart Problems	Yes	No	Osteoporosis/Osteopenia	Yes	No
Bleeding Disorder/Clots	Yes	No	Hepatitis	Yes	No	Skin Disorders	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stomach Problems	Yes	No
Depression/Anxiety	Yes	No	Kidney/Liver Problems	Yes	No	Tuberculosis (or exposure)	Yes	No
Diabetes	Yes	No	Lung Disease	Yes	No	Other: _____		

PREVIOUS SURGERIES AND DATE (Month/Year)

1.	4.	7.
2.	5.	8.
3.	6.	9.

SOCIAL HISTORY

Amount used per Day, Week, or Month

Occupation: _____Highest Education: _____
Current Residence (City/State):_____ # Years: _____
Current Marital Status: Married Single
Number of Children: _____ Ages: _____

Alcohol Use: _____
Tobacco Use: _____
Caffeine Use: _____
Illicit Drug Use: _____

HISTORY OF FAMILY - PARENTS & SIBLINGS - HEALTH PROBLEMS – DESCRIBE:

REVIEW OF CURRENT SYMPTOMS

Are you (or the child) currently having or have you had in the last 30 days problems with your (check boxes that are positive and explain)

Constitutional	No	Yes	Fatigue❑	Fevers❑	Chills❑	Weight Loss❑	Weight Gain❑	Weakness❑ Other: _____
Eyes	No	Yes	Dry Eyes❑	Blurred Vision❑	Pain❑	Redness❑	Other:_____	
Ears, Nose, Throat	No	Yes	Hearing Loss/Ringing❑	Nosebleeds❑	Mouth Sores❑	Dry Mouth❑	Difficulty Swallowing❑	Other: _____
Lungs, Breathing	No	Yes	Shortness of Breath❑	Wheezing❑	Cough❑	Other: _____		
Heart	No	Yes	High Blood Pressure❑	Chest Pain❑	Irregular Heartbeat❑	Heart Murmurs❑	Explain: _____	
Gastrointestinal	No	Yes	Nausea❑	Vomiting❑	Stomach Aches❑	Constipation❑	Diarrhea❑	Blood in Stool❑ Other: _____
Bladder	No	Yes	Difficulty Urinating❑	Pain/Burning on Urination❑	Incontinence❑	Urinary Tract Infections❑	Other:_____	
Endocrine	No	Yes	Diabetes❑	Thyroid Problems❑	Delays in Growth❑	Other: _____		
Musculoskeletal	No	Yes	Joint Pain❑	Joint Swelling❑	Muscle Weakness❑	Muscle Pain❑	Morning Stiffness❑	Other: _____
Bleeding problems	No	Yes	Anemia❑	Prolonged Bleeding after Cut/Injury❑	Other: _____			
Neurological	No	Yes	Numbness/Tingling❑	Dizziness❑	Headaches❑	Frequent Falls❑	Other: _____	
Integumentary	No	Yes	Hair Falling Out❑	Sun Sensitivity❑	Rashes❑	Skin Disorders❑	Color Changes of Hands/Feet❑	Other:_
Psychiatric	No	Yes	Change in Mood or Behavior❑	Change in Sleep Patterns❑	Difficulty Sleeping❑	Other: _____		
Immunologic/Allergic	No	Yes	Asthma❑	Current Cold or Flu❑	Seasonal Allergies❑	Hay Fever❑	Other: _____	

Who referred you to our office? _____

Who is your Primary Care Physician? _____

Signature: _____ Date: _____/_____/_____

OFFICE USE:
Reviewed by:_____ Date:_____/_____/_____

HARD COPY TO PROVIDER BEFORE VISIT – REVIEW AT VISIT – SCAN AFTER VISIT UPDATE 082009