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Diplomate American Board of Rheumatology
Diplomate American Board of Internal Medicine

Patient History Form

Name:_____ **Birthdate:**___/___/_____

Describe briefly your present symptoms: _____

_____

Date symptoms began (approximate): _____

Previous treatment for this problem (include physical therapy, surgery and injections; (medications to be listed later) _____

_____

_____

Preferred Pharmacy

Pharmacy name: _____ Address: _____ Phone: _____

PAST MEDICAL HISTORY

Do you now or have ever had: (√, if yes)

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Tuberculosis	☐Stroke
☐ Cataracts	☐ Emphysema	☐ Epilepsy
☐ Anemia	☐ Stomach ulcers	☐ Colitis
☐ Jaundice	☐ Nervous breakdown	☐ HIV/AIDS
☐ Glaucoma	☐ Rheumatic fever	☐ Diabetes
☐ Leukemia	☐ High blood pressure	
☐Pneumonia	☐ Kidney disease	

Previous Operations

Type	Year	Reason

Any previous fractures? ☐ Yes ☐ No Describe: _____

Any other serious injuries? ☐ Yes ☐ No Describe: _____

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MEDICATIONS

Drug allergies: ☐ Yes ☐ No To what? _____

_____

Type of reaction: _____

Present Medications (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Name of prescribing Physician