LOUDOUN
RHEUMATOLOGY
CENTER
Healthy Joints . Healthy Bones

NEW PATIENT HISTORY FORM

Date: ____/____/____

Patient Name: ____ Date of Birth: ____/____/____ Sex: _________

Primary Care Physician: ____

Chief Complaint: ____

____

____

Medications/Dosage: ____

Present: ____

In the Last Year: ____

Pharmacy/Phone: ____

Are you allergic to or intolerant of any drugs? If yes, please list the drugs and your reaction: ________

____

Past operations/Dates: ____

____

Other Major Illnesses & Hospitalizations: ____

Do you smoke? ______ Pack(s)/Day: ______/______ Did you smoke? _______ Date Stopped? _________

How often do you have a drink? (Beer, Wine, Liquor) ____

Do you take any vitamins/supplements (Please list):____

Please circle if there is any family history of:

Arthritis   Diabetes   Asthma   Heart Disease   Kidney Disease   Stroke

High Blood Pressure   Alcoholism   Gout   Lupus

Mental Illness   Scleroderma   Osteoporosis   Cancer   Tuberculosis

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