LOUDOUN RHEUMATOLOGY CENTER
Healthy Joints . Healthy Bones

NEW PATIENT HISTORY FORM

Date: _____

Patient Name: (Last)	(First)	Date of Birth _____/_____/_____	Sex M F

Chief Complaint: _____

Primary Care Physician Name		**Number**	
Specialist Name		**Number**	
Pharmacy Name		**Number**	

Current Medications and dosage: _____

_____

Do you take and vitamins/supplements? (Please list) _____

_____

Are you allergic to any medication drugs? If YES, please list the drug AND your reaction: _____

_____

Past operations and the year they were preformed: _____

_____

Do you smoke? Y/N Pack(s)/Day _____ Did you smoke? Y/N Date Stopped _____

How often do you drink? (Beer, Wine, Liquor) _____

Does your family have any history of the below conditions? If so please label who. This does not include your history.

Condition	Answer	Relative	Condition	Answer	Relative
Arthritis	Y / N		Gout	Y / N	
Diabetes	Y / N		Lupus	Y / N	
Asthma	Y / N		Mental Illness	Y / N	
Heart Disease	Y / N		Scleroderma	Y / N	
Kidney Disease	Y / N		Osteoporosis	Y / N	
Stroke	Y / N		Cancer	Y / N	
High Blood Pressure	Y / N		Tuberculosis	Y / N	
Alcoholism	Y / N				