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**	
Referring Doctor Name		**Number**	
Pharmacy Name		**Number**	

Current Medications and dosage including vitamins/supplements:

_____

_____

_____

List allergies to medication drugs. Please list the drug AND your reaction:

_____

_____

Significant medical problems:

_____

_____

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 indicate who. This does not include your history.

Condition		Relative	Condition		Relative
Rheumatoid Arthritis	Y / N		Scleroderma	Y / N	
Lupus	Y / N		Ankylosing Spondylitis	Y / N	
Psoriasis	Y / N		Kidney Disease	Y / N	
Fibromyalgia	Y / N		Stroke	Y / N	
Gout	Y / N		Cancer	Y / N	
Osteoporosis	Y / N		Tuberculosis	Y / N	