COMMUNITY CARE RHEUMATOLOGY
OF COMMUNITY CARE PHYSICIANS

6 Wellness Way, Suite 106, Latham, NY 12110
Phone: (518) 782-3899 • Fax: (518) 782-3884

Medical History Form

Patient Name: ____ DOB: _______________________ Date: _________________________

Reason for Visit: ____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: e.g., Folic Acid	**Dosage:** e.g., 1 mg	**Instructions:** e.g., 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: e.g., penicillin	**Reaction:** e.g., Hives

Past Medical History:	*Self*	*Family Member*		*Self*	*Family Member*
Rheumatoid Arthritis	◯	______________________	Stroke	◯	______________________
Lupus	◯	______________________	COPD	◯	______________________
Psoriatic Arthritis	◯	______________________	Asthma	◯	______________________
Ankylosing Spondylitis	◯	______________________	Diabetes	◯	______________________
Uveitis/Scleritis	◯	______________________	Chronic Kidney Disease	◯	______________________
Crohn’s/Ulcerative Colitis	◯	______________________	GERD	◯	______________________
Sjogren’s Syndrome	◯	______________________	Stomach Ulcers	◯	______________________
Scleroderma	◯	______________________	Hypothyroidism	◯	______________________
Pulmonary Hypertension	◯	______________________	Cancer	◯	______________________
Psoriasis	◯	______________________	Anemia	◯	______________________
Osteoporosis/Osteopenia	◯	______________________	Prostate	◯	______________________
Gout	◯	______________________	Macular Degeneration	◯	______________________
Osteoarthritis	◯	______________________	Glaucoma	◯	______________________
Coronary Artery Disease	◯	______________________	Depression	◯	______________________
High Cholesterol	◯	______________________	Anxiety	◯	______________________
High Blood Pressure	◯	______________________	Seizures	◯	______________________
Congestive Heart Failure	◯	______________________	Lung Clot/DVT	◯	______________________

Other Major Illness:

____
____

Surgical History: Please list all past operations with dates

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Social History: Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: ◯ Male ◯ Female *Marital Status:* ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Other: ________________________
Primary Language: ◯ English ◯ French ◯ Spanish ◯ Other: __________________ *Occupation:* ________________________

Number of Pregnancies: __________ *Number of Children*: __________________ *Number of Miscarriages*: _____________

Tobacco Use: ◯ Never smoked ◯ Currently smoke (# packs per day) _______ ◯ I have quit smoking (age when stopped) _____________

Alcohol Use: How many days per week to you drink? ____ # of drinks per day? ____ Have you ever had a problem with alcohol? ________

Recreational Drug Use: Do you use drugs? ◯ Yes ◯ No How often? _______ Have you ever had a problem with illicit drugs? __________

Pharmacy:
Retail: _______________________ Address: _______________________ Phone: _______________________
Retail: _______________________ Address: _______________________ Phone: _______________________
Mail Order: ___________________ Address: _______________________ Phone: _______________________

Names of Physicians/Other Specialists which are treating you:
Name: _______________________________ Phone: _________________ Specialty: ____________________
Name: _______________________________ Phone: _________________ Specialty: ____________________
Name: _______________________________ Phone: _________________ Specialty: ____________________
Name: _______________________________ Phone: _________________ Specialty: ____________________

In the past month, have you experienced any of the following? Check box if yes.

□ Weight change
□ Chills
□ Fever
□ Night sweats
□ Feeling tired or poorly
□ Headache
□ Facial pain
□ Sinus pain
□ Head-related symptoms
□ Easy bleeding
□ Easy bruising
□ Neck pain
□ Lump or swelling in the neck
□ Breast pain
□ Nipple discharge
□ Breast lump
□ Chest pain
□ Pounding heartbeat
□ Palpitations
□ Rash
□ Skin lesion
□ Itching
□ White or purple fingers or toes
□ Pain during urination
□ Urinary frequency
□ Blood in urine
□ Genital lesion
□ Vaginal discharge
□ Pain during intercourse
□ Incontinence
□ Excessive sweating
□ Excessive thirst
□ Hot flashes
□ Decrease in height
□ Vision problems
□ Eye sensitivity
□ Sinus pain
□ Eyes itch
□ Earache
□ Loss of hearing
□ Ringing in ears
□ Nosebleeds
□ Nasal discharge
□ Mouth sores
□ Bleeding gums
□ Hoarseness
□ Sore throat
□ Shortness of breath
□ Cough
□ Wheezing
□ Poor appetite
□ Difficulty swallowing
□ Heartburn
□ Nausea
□ Vomiting
□ Abdominal pain
□ Diarrhea
□ Black or tarry stools
□ Constipation
□ Joint pain
□ Joint stiffness
□ Joint swelling
□ Muscle aches
□ Back pain
□ Muscle weakness
□ Dizziness
□ Fainting
□ Motor disturbances
□ Sensory disturbances
□ Sleep disturbance
□ Anxiety
□ Depression

Patient Name: ______________________________ Patient Signature: ______________________________ Date: _________________