

Name: _____ Age: _____ Occupation: _____ Marital Status: _____

Have you ever had the following: (please circle if yes)

Psoriasis, iritis (very painful and reddened eye), bloody diarrhea, venereal disease, seizures, kidney failure, prolonged facial rash with sun exposure, severe patch hair loss, sores in the mouth, pleurisy, pericarditis, hands turn color with cold exposure (white, blue, red), dry eyes, dry mouth.

Prior hospitalizations:

Year	Hospital	Reason
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Others: _____

Prior surgeries:

Year	Hospital	Type of surgery
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Present medications:

Name	mgs.(strength)	Times per day taken
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____

Others: _____

Medication allergies: _____

Is there a family history of arthritis? (relation and type of arthritis) _____

Do you smoke? _____ no _____ yes. If yes, how much? _____

Do you drink alcohol _____ no _____ yes. If yes, how much? _____

Do you have stiffness in the morning? _____ no _____ yes. If yes, give duration _____ min. _____ hrs.

Medical problems past or present (please circle if yes):

- 1) ENT: frequent sinusitis, nasal polyps, nosebleeds, laryngitis.
- 2) HEART: chest pain, fluid around the heart, heart attack, heart murmur, mitral valve prolapse.
- 3) LUNGS: cough, tuberculosis, valley fever, cough up blood, short of breath.
- 4) GASTROINTESTINAL: nausea, vomiting, vomit blood, diarrhea, weight loss, stomach ulcer, duodenal ulcer, hepatitis, yellow jaundice, black tarry stool, bright red blood per rectum.
- 5) OTHERS: diabetes, high blood pressure, prior transfusion, stroke, cataracts, glaucoma, cancer, hemorrhoids, anal fissure, fever, chills, loss of appetite.
- 6) OTHERS: _____

Temperature _____ Pulse _____ BP: _____ Respirations _____ Weight _____