Arthritis & Osteoporosis Associates

ADULT HISTORY FORM

Patient Name: _________________________________ Date of Birth:__________ Date:___________

Please briefly explain the reason for today's visit: ____

____

Patient Medical History: *Please check all that apply:*

☐ High blood pressure ☐ History of fractures ☐ Ulcerative Colitis

☐ Heart disease ☐ Thyroid disease ☐ Cancer (type): __________

☐ Diabetes ☐ Irritable Bowel Syndrome ☐ Other : ________________

☐ Asthma ☐ Crohn's Disease

Patient Social History:

Do you use tobacco products? ☐ No ☐ Yes If yes, what type of tobacco product? ____________________

Do you drink alcohol? ☐ No ☐ Yes If yes, please provide type and frequency. _______________________

Caffeine use? ☐ No ☐ Yes If yes, please provide type and frequency. ______________________________

Level of Activity/Exercise: ☐ Vigorous ☐ Regular ☐ Occasional ☐ None Type of Exercise: ______________

Illicit Drug Use: ☐ No ☐ Yes If Yes, please provide type, quantity, frequency:________________________

Patient Family History: *Please check all that apply to your* ***FAMILY*** *history and provide relation to you:*

☐ Rheumatoid Arthritis (Relation):____________ ☐ Gout (Relation):________________________

☐ Psoriatic Arthritis (Relation):_______________ ☐ Psoriasis (Relation):_____________________

☐ Osteoarthritis (Relation):__________________ ☐ Ulcerative Colitis (Relation):_______________

☐ Lupus (Relation):________________________ ☐ Crohn's Disease (Relation):________________

Surgical History: *Please list all past surgeries including the month and year:*

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Allergies: *Please list all known allergies and reactions: Or check here if:* ☐ No Known Allergies

Allergy	Allergic Reaction

Primary Local Pharmacy:

Name: ____

Address: ____

Phone #: ____

Specialty/Mail Away Pharmacy:

Name: ____

Address: ____

Phone #: ____

Print Name: ________________________________

*Signature:*________________________________

*Date:*____________________________________

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Patient Name: ____

Adult Medication Sheet

Date of Birth: ____

Medication Name	Dose/Route	Frequency	Start Date

Please list any short-term medications that you are currently taking or just finished:

Medication Name	Dose/Route	Frequency	Start/Stop Date(s)

Patient Signature: ____ **Date:**____________________________