

**Arthritis and Osteoporosis Associates**  
**New Patient Information Form**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

**HISTORY**

Chief Complaint (Describe Major Symptoms) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

History of Present Illness (Include: location, severity, timing, associated symptoms, duration) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Surgical History \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY**

Condition	Yes	No	Diagnosis Date	Condition	Yes	No	Diagnosis Date
Cardiac Arrest				High Triglycerides			
Heart Attack				Asthmas/Emphysema			
Diabetes				Thyroid Disease			
Hypertension				Anemia			
Stroke/TIA				Migraines			
CAD(coronary artery disease)				Ulcers			
Heart Murmur				Colitis			
Arthritis/Gout				Hepatitis			
Osteoporosis				Kidney Disease			
Bleeding Tendency				HIV(AIDS)			
Convulsions				High Cholesterol			
Rheumatic Fever				Hereditary Defects			

Heart Rhythm Problem \_\_\_\_\_ Psychiatric Disorder \_\_\_\_\_

Cancer (type) \_\_\_\_\_ Other medical condition \_\_\_\_\_

Allergic to iodine, latex, shellfish, Tree Nuts/Peanuts, or x-ray dye? YES NO

LIST ANY ALLERGIES/MEDICATION INTOLERANCES IN THE SPACE BELOW:

RHEUMATOLOGICAL	Y/N
Pain Level (1 mild to 10 extreme)	
Tenderness	
Swelling	
Joint Pain	
Fatigue	
Rash	

SOCIAL HISTORY				
Use of Alcohol	Never	Rarely	Moderately	Daily
Use of Tobacco	Never	Previously / Date Quit ___/___/___	Yes	Current Packs/Day _____
Use of Drugs	Never	Yes	IF YES: Type _____ Frequency _____	
Caffeine Use	Never	Yes	IF YES: # of Cups per Day _____	

FAMILY MEDICAL HISTORY	Age	IF DECEASED: Cause of Death & Age	Disease/s
Father			
Mother			
Grandmother			
Grandfather			
Sibling			
Sibling			



Arthritis & Osteoporosis  
Associates  
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