



## HEALTH HISTORY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year (xxxx)

Which physician referred you to our practice? \_\_\_\_\_

Name of Local Pharmacy \_\_\_\_\_ Local Pharmacy Phone \_\_\_\_\_

Name of MAIL ORDER Pharmacy \_\_\_\_\_ Mail Order Pharmacy Phone \_\_\_\_\_

**PLEASE LIST ALL CURRENT MEDICAL CONDITIONS FOR WHICH YOU ARE RECEIVING TREATMENT:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE LIST ANY PREVIOUS SURGERIES:**

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

**PLEASE LIST ALL CURRENT MEDICATIONS, OR BRING A DETAILED MEDICATION LIST:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PLEASE LIST ANY DRUG ALLERGIES:**

\_\_\_\_\_  
 \_\_\_\_\_

In which city do you reside? \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Number of children: \_\_\_\_\_ Pregnancies: \_\_\_\_\_ Miscarriages and if so, what trimester: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Smoking History:  Current  Former  Never If so, how many packs? \_\_\_\_\_ If former, date you quit: \_\_\_\_\_

Do you currently consume alcohol?  Yes  No If yes, how much? \_\_\_\_\_ How often: \_\_\_\_\_

Does anyone in your immediate family have a history of rheumatoid arthritis, lupus, Sjögren's syndrome, scleroderma, polymyositis, gout, Crohn's disease, ulcerative colitis, ankylosing spondylitis, or psoriasis?

If yes, please list the condition(s) and the family member(s): \_\_\_\_\_

Does anyone in your family have osteoporosis?  Yes  No If yes, who? \_\_\_\_\_

Have you ever had a bone density test?  Yes  No If yes, when and where? \_\_\_\_\_

**RHEUMATOLOGY MEDICATION HISTORY**

MEDICATION NAME	DID IT HELP?	DESCRIBE ANY SIDE EFFECTS OR PROBLEMS
Actemra	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Azathioprine (Imuran)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bimzelx	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cellcept / Mycophenolate / Olumiant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cimzia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cosentyx	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Enbrel	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Humira or Biosimilar	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ibuprofen or other NSAIDs (e.g., Naproxen, Mobic, Celebrex, Aleve)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ketvara	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kineret	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leflunomide (Arava)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Methotrexate	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Orencia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Otezla	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Plaquenil (Hydroxychloroquine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Remicade / Renflexis / Inflectra / Avsola	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rinvoq	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rituxan / Ruxience / Truxima	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Simponi	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Simponi Aria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skyrizi	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stelara	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sulfasalazine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Taltz	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tremfya	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Xeljanz	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Medications (Please List):		

\_\_\_\_\_  
*Signature of Patient or Patient's Legal Representative*

\_\_\_\_\_  
*Month / Day / Year*

\_\_\_\_\_  
*Printed Name of Patient or Legal Representative*

\_\_\_\_\_  
*Relationship to Patient*