Medical History

Patient Information:

Patient Last Name		First Name	Date of Birth
Reason for Visit		Allergies	
Preferred Pharmacy	Pharmacy Telephone	Pharmacy Address	

Please list your current medications:

1.	mg	6.	mg
2.	mg	7.	mg
3.	mg	8.	mg
4.	mg	9.	mg
5.	mg	10.	mg

Please list medications you have tried *in the past* for your autoimmune condition(s):

1.	mg	3.	mg
2.	mg	4.	mg

Please list any diseases, illnesses, or surgeries you have now or have had previously:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

History of Smoking and Alcohol Use:

Do you currently drink alcohol? ☐ Yes ☐ No	Did you used to drink alcohol? ☐ Yes ☐ No
Do you currently smoke tobacco? ☐ Yes ☐ No	Did you used to smoke tobacco? ☐ Yes ☐ No

Please list the physicians who care for you now or have cared for you in the past:

1.	3.
2.	4.

Please indicate below the history of arthritis or rheumatic disease in your family:

	Mother	Father	Sibling(s)
Rheumatoid Arthritis			
Gout			
Psoriasis			
Lupus			
Other			