

# RHEUMATOLOGY & OSTEOPOROSIS CENTER OF MEMPHIS, P.C.

1. NAME: \_\_\_\_\_ 2. AGE: \_\_\_\_\_

3. REASON FOR SEEING THE DOCTOR: \_\_\_\_\_  
 \_\_\_\_\_

4. PRESENT MEDICATIONS: \_\_\_\_\_  
 \_\_\_\_\_

5. RECENT MEDICATIONS INCLUDING OVER THE COUNTER: \_\_\_\_\_

6. ALLERGIES TO MEDICATIONS: \_\_\_\_\_

7. HAVE YOU OR ANY FAMILY MEMBER HAD: (PLEASE CHECK)

	PATIENT	MOTHER	FATHER	BROTHER	SISTER	GRAND-PARENTS	CHILDREN
a. Heart Disease:							
b. Hypertension:							
c. Lung Disease:							
d. High Cholesterol:							
e. Diabetes:							
f. Cancer:							
g. Stroke:							
h. Tuberculosis:							
i. Arthritis - what kind:							
j. Systemic Lupus:							
k. Kidney Stones:							
l. Hepatitis:							
m. Psoriasis							

8. CAUSE OF DEATH AND AGE: MOTHER: \_\_\_\_\_  
 FATHER: \_\_\_\_\_

9. OPERATIONS IN THE PAST: \_\_\_\_\_  
 \_\_\_\_\_

10. SERIOUS MEDICAL ILLNESS: \_\_\_\_\_  
 \_\_\_\_\_

11. SERIOUS INJURIES: \_\_\_\_\_  
 \_\_\_\_\_

12. BLOOD TRANSFUSIONS IN THE PAST: \_\_\_\_\_ WHEN: \_\_\_\_\_

13. DO YOU SMOKE: \_\_\_\_\_ HOW MUCH: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

14. DO YOU DRINK ALCOHOL: HOW MUCH: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

15. SPOUSES AGE: \_\_\_\_\_ YOUR OCCUPATION: \_\_\_\_\_

16. DO YOU EXERCISE REGULARLY: \_\_\_\_\_ DO YOU FOLLOW A SPECIAL DIET: \_\_\_\_\_

17. WOULD YOU LIKE A REPORT OF THIS EXAMINATION TO BE SENT TO ANOTHER PHYSICIAN?: \_\_\_\_\_  
 \_\_\_\_\_

18. ADDITIONAL INFORMATION - (If needed, use back of sheet): \_\_\_\_\_  
 \_\_\_\_\_