ARTHRITIS RHEUMATOLOGY CONSULTANTS
SUGAR LAND & HOUSTON, TX

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Patient Information Form

Patient Name: _____
First Name Last Name MI

Date of Birth: _____ SSN #: _____ Gender: ☐ Male ☐ Female

Address: _____

City/State: _____ Zip Code: _____

Home #: _____ Cell #: _____

E-mail Address: _____

Pharmacy Information (Name, Phone and/or Address): _____

May we contact you on the phone? ☐ Yes ☐ No

Check where we may leave messages about appointments, lab/x-ray results, or other health related information:

Home answering machine/voicemail: ☐ Yes ☐ No
Cell Phone: ☐ Yes ☐ No
Family Member: ☐ Yes ☐ No
E-mail ☐ Yes ☐ No

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Primary Care Provider/Referring Physician: Referring Physician
Name:_____ Address:_____

Referring Physician Phone #: _____ Referring Physician Fax #: _____

Referring Provider (if different from above) or Person:

Name: _____ Address:_____

Provider Phone #: _____ Provider Fax #: _____

Patient Signature: _____ Date: _____

Patient Medical History Form

Patient Name: _____ Date of Birth: _____
First Name Last Name MI

Pharmacy Name: _____

Pharmacy Phone: _____

Do you have an advance directive (living will)? Yes ☐ No ☐

Are you the surrogate decision maker (individual decision maker)? Yes ☐ No ☐

REASON FOR YOUR OFFICE VISIT: _____

Medication: Please list all prescription medications, over the counter vitamins, and supplements,weightloss medication.

Medication/Supplement Name	Dose/Frequency		Medication/Supplement Name	Dose/Frequency

Allergies: Do you have any allergies or adverse reactions to ANY medications?

Medication	Reaction		Medication	Reaction

Medical History: Please list any medical problems you have had in thepast.

Medical Problem	Date Occurred		Medical Problem	Date Occurred

Patient Name: _____ Date of Service: _____

Surgical History: **NO PRIOR SURGERIES** ☐

Procedure Name	Date (M/Y)		Procedure Name	Date (M/Y)

Hospitalizations: Please list any hospital admissions. **NO PRIOR HOSPITALIZATIONS** ☐

Procedure Name	Date (M/Y)		Procedure Name	Date (M/Y)

Family History:

	Diabetes	**Hypertension**	**Heart Disease**	**Rheumatic History**
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Siblings				
Children				
Other Relatives				

Siblings: _____Brother(s) _____Sister(s) Children: _____Sons(s) _____Daughter(s)

Please check all that apply:**Social History:**

Tobacco Use: ☐Never ☐Former* ☐Current * Quit: _____(Month) / _____(Year)

Circle one: Light (1-9 cigs/day) Moderate (10-19 cigs/day) Heavy (20-39 cigs/day)

Alcohol Use: ☐Never ☐Former* ☐Current ☐Beer ☐Wine ☐Hard Liquor

Drinks/Amount (per day/week/month) _____ * Quit: _____(Month) / _____(Year)