Height: ________________ Weight: _______________

Review of Symptoms- Please

○ Weight Loss/Gain ○ Fever ○ Arm Numbness ○ Stiffness ○ Sever Nighttime pain ○ Difficulty Buttoning Buttons ○ Change in Writing Ability	○ Night Sweats ○ Recent Infections ○ Leg Numbness ○ Swelling ○ Difficulty Walking ○ Rashes ○ Bleeding/Bruising	○ Mood Changes ○ Poor Sleep ○ Fatigue ○ Muscle Weakness ○ Joint Pain ○ Genital Numbness ○ Bowel Incontinence	○ Bladder Infections ○ Changes in Appetite ○ Other (describe) ____________________ ____________________ ____________________

check all that apply to you.

Past Medical History

○ Heart Disease ○ Liver Disease ○ Seizures/Epilepsy ○ Cancer (Specify): ________________ ________________	○ High Blood Pressure ○ Lung Disease ○ Thyroid Disease ○ Other (Specify): ________________ ________________	○ Diabetes ○ Ulcers ○ Psychiatric Illness	○ Kidney Disease ○ Acid Reflux ○ High Cholesterol	○ Osteoporosis ○ Osteoarthritis ○ Rheumatoid Arthritis

Allergies

- ○ Penicillin: reaction_________________
- ○ Iodine: reaction__________________
- ○ Sulfa:___________________________
- ○ Codeine:_________________________
- ○ Other:__________________________
- ○ **None**

Family History-Please check any disease diagnosed in your blood r e

- ○ Cancer
- ○ Stroke
- ○ Heart Disease
- ○ Diabetes
- ○ Neck/Low Back Pain
- ○ Arthritis
- ○ Other:_____________________________

.

Social History-Please circle one.

Do you Smoke? Yes No How much? ______________________________

Do you Drink Alcohol? Yes No How much? ______________________________

Do you use Illegal Drugs? Yes No How much? ______________________________

Are you: Single Married Widowed Separated

Are you currently working? Yes No How long have you not been working?

Highest level of education: High School College GED

Do you live: Alone With: ______________________________

Are you: Employed Retired Disabled

If employed-What is your occupation?