Lancaster Arthritis & Rheumatology Care Medication Information Form

NAME ____________________ DATE OF BIRTH____________________
FAMILY DOCTOR ____________________ PHONE NUMBER ________________

WHAT PROBLEM ARE YOU BEING SEEN FOR? ____________________

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MEDICATIONS AND SUPPLEMENTS:

NAME OF MEDICATION	DOSE	HOW OFTEN

ALLERGIES:

NAME OF ALLERGEN	WHAT HAPPENED?

MEDICAL PROBLEMS – CIRCLE ALL THAT APPLY

DIABETES	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	HEART FAILURE	COPD
KIDNEY DISEASE	CANCER	THYROID DISEASE	STROKE	ASTHMA
ULCERS	DEPRESSION	ANXIETY	ARTHRITIS	OSTEOPOROSIS

LIST ANY OTHER PROBLEMS: ____________________

PLEASE LIST YOUR SURGERIES:

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HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? CIRCLE ALL THAT APPLY

FEVER	DRY EYES	HEARTBURN	CHEST PAIN	DIFFICULTY SLEEPING
CHILLS	EYE INFLAMMATION	DIFFICULTY SWALLOWING	LEG SWELLING	GENERALIZED WEAKNESS
WEIGHT LOSS	DRY MOUTH	BLOOD IN STOOL	JOINT SWELLING	SWOLLEN GLANDS
HAIR LOSS	ORAL ULCERS	BLOOD IN URINE	JOINT PAIN	BLOOD DISORDER
SKIN RASH/SUN SENSITIVITY	ABDOMINAL PAIN	KIDNEY STONES	MUSCLE PAIN	EASY BRUISING
PSORIASIS	DIARRHEA	PAINFUL URINATION	STIFFNESS	MISCARRIAGE
HEARING LOSS	CONSTIPATION	SHORTNESS OF BREATH	NUMBNESS OR TINGLING	FATIGUE
VISION CHANGES	NAUSEA/ VOMITING	COUGH	HEADACHES	ANXIETY/ DEPRESSION

SOCIAL HISTORY:

OCCUPATION ____

ALCOHOL USE: NO________ YES ________ HOW MUCH ____

TOBACCO USE: NO ________ YES ________ HOW MUCH ____

ILLICT DRUG USE: NO ________ YES ________ WHAT/HOW OFTEN ______________________________

MARRIED _____ SINGLE _____ WIDOWED/WIDOWER ______ DIVORCED ______ ENGAGED ______

FAMILY HISTORY:

RELATIVE	HEALTH PROBLEMS
FATHER	
MOTHER	

PLEASE LIST ANY OTHER INFORMATION YOU WOULD LIKE TO TELL YOUR DOCTOR:

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