Arthritis Medical Clinic

Osteoporosis Diagnostic Imaging & Treatment Center

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HEALTH QUESTIONNAIRE

Patient ID_____

Name_____ Date_____

Please provide detailed information about your health. Complete the questionnaire as much as possible. This will remain a confidential part of your medical record.

1. **WHY ARE YOU HERE?** _____

2. List all medications you are currently taking. _____
_____
_____
_____
_____

3. Health History (Check all that apply)

☐ Rheumatoid Arthritis	☐ Osteoarthritis	☐ Psoriasis	☐ Psoriatic Arthritis
☐ Osteoporosis	☐ Gout	☐ Fibromyalgia	☐ Lupus
☐ Sjogran	☐ Ankylosing Spondylitis	☐ Polymyositis	☐ Polymyalgia Rheumatica
☐ Thyroid Disease	☐ Tuberculosis	☐ Diabetes	☐ Anemia
☐ Depression	☐ Anxiety	☐ Blood Pressure	☐ Pneumonia
☐ Heart Disease	☐ Kidney Disease	☐ Acid Reflux	☐ Stomach Ulcer
☐ Kidney Stone	☐ Disc Damage	☐ Liver Disease	☐ High Cholesterol
☐ Crohns Disease	☐ Ulcerative Colitis	☐ Back pain	☐ Cancer

Other_____

4. Any history of surgery? _____
_____

5. List allergies to any medications _____

6. Personal/ Social History
   a. Marital (check one): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
   b. Number of children _____
   c. Menstrual & Pregnancy History (Females)
      Pregnancies: Number _____ Live Births _____ Miscarriage _____ Abortions _____
   d. Your Occupation _____
   e. Personal Habits: Tobacco (Amt.) _____ Alcohol (Amt.) _____ Other drugs_____

7. Family History: Mother ☐ alive ☐ deceased Father ☐ alive ☐ deceased

   Family Illnesses (Check all that apply)

☐ Rheumatoid Arthritis	☐ Lupus	☐ Gout	☐ Osteoarthritis	☐ Fibromyalgia
☐ Osteoporosis	☐ Sjogren	☐ Depression	☐ Diabetes	☐ Heart Disease
☐ High Blood Pressure	☐ Cancer	☐ Kidney Disease	☐ Kidney Stones	☐ Tuberculosis
☐ Allergy	☐ Strokes	☐ Bleeding problem		

   Other _____

8. Please answer the following:
   a. Are you Depressed? _____
   b. Do you Have Stress / anxiety? _____
   c. How many Hours do you Sleep? _____
   d. Do you have: (Check all that apply) ☐ Mood Swing ☐ Memory Loss ☐ Severe Headache ☐ Fatigue
   e. Do you Exercise Regularly? ☐ No ☐ Yes What type? _____ How Often? _____

9. Which of the following applies to you? (Check all that apply)

☐ Constant Dry Eye	☐ Excessive Weight Loss	☐ Sensitivity to Sun (Photosensitivity)	☐ Mouth Sore	☐ Skin rash
☐ Constant Dry Mouth	☐ Excessive Hair Loss	☐ Color Change of Fingers/toes (Raynaud's)	☐ Joint Swelling	☐ Facial rash