# Arthritis Medical Clinic

**Osteoporosis Diagnostic Imaging & Treatment Center**

6180 Brockton Ave, Suite 204 • Riverside, California 92506

(951) 781-7700 • FAX (951) 781-0313


## HEALTH QUESTIONNAIRE

Name_____ Date_____

*Complete the questionnaire as much as possible. This will remain a confidential part of your medical record.*

1. **Visit Reason?** ☐Abnormal Labs ☐Joint Pain ☐Other:_____

2. **Health History** (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Anxiety | ☐ Diabetes (Type 1 or 2) | ☐ Kidney Stones | ☐ Stomach Ulcers |
| ☐ Thyroid Disease | ☐ Blood Pressure | ☐ Liver Disease | ☐ High Cholesterol |
| ☐ Depression | ☐ Kidney Disease | ☐ Stroke (Date:_____) | |
| ☐ Thyroid Disease | ☐ Heart Stent/Bypass (Date:_____) | | |

☐ Heart Attack (Date:_____)

☐ Cancer (Type: _____ Date of last treatment_____)

3. **History of surgery?** Yes or No. *If yes, please list:*_____

_____

4. **Allergies:** ☐ Sulpha Drugs ☐ Vaccines ☐ Antibiotics (list them):_____ ☐ Other_____

_____

5. **Personal/ Social History:**

Marital (check one): ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Menstrual & Pregnancy History (Females) *Spontaneous Miscarriage*_____

Your Occupation _____

6. **Personal Habits:**

Tobacco: ☐ Past (Year Stopped_____) ☐ Current Use (Packs per day:_____) ☐ Never

Alcohol: ☐ Less than once weekly ☐ Once Weekly or More ☐ Never

Recreational Drug Use: ☐ Marijuana ☐ CBD ☐ Other_____ ☐ Current Use ☐ Past Use

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

| | | | |
|---|---|---|---|
| ☐ Cancer | ☐ Kidney Disease | ☐ High Blood Pressure | ☐ Heart Disease |
| ☐ Osteoporosis | ☐ Bleeding Problem | ☐ Strokes | ☐ Diabetes |

Babak Zamiri , MD
Nayef Kazzaz, MD
Asbat Hasan, MD
Noemi Lopez, FNP

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ARTHRITIS MEDICAL CLINIC

**Please check which symptoms you have experienced in the last seven days.**

| **Constitutional** | | **Genitourinary** | | **Allergic/Immunologic** | |
|---|---|---|---|---|---|
| Chills | | Dysuria | | Seasonal allergies/hayfever | |
| Fatigue | | Genital lesions | | Itching and skin rash | |
| Fever | | Blood in urine | | | |
| Night sweats | | Frequent urination at night | | **Psychiatric** | |
| Wweight gain (unintentional) | | Frequent urination | | Anxiety | |
| weight loss (unintentional) | | | | Crying spells | |
| | | **Musculoskeletal** | | Depression | |
| **Eyes** | | Joint pain | | Feel stressed | |
| Blurry vision | | Back pain | | Loss of interest in pleasurable activity | |
| Eye drainage | | Joint stiffness | | Poor concentration | |
| Eye pain | | Limb pain | | Recreational drug use | |
| Dry eyes | | Muscle pain | | Sadness | |
| Sensitivity to light | | Weakness | | Sleep disturbance | |
| | | Poor ambulation | | Suicidal thoughts | |
| **Ears/ Nose/Throat** | | Deformities | | | |
| Difficulty swallowing | | Swelling | | | |
| Dry Mouth | | | | | |
| Nosebleed | | **Skin** | | | |
| Non-healing nasal ulcer | | Dry skin | | | |
| Bleeding Gums | | Itching | | | |
| Sore/Ulcer in mouth | | Rashes | | | |
| Sore tongue | | Ulcerations | | | |
| | | Sun sensitivity | | | |
| **Cardiovascular** | | Color changes | | | |
| Chest pain | | | | | |
| Palpitations | | **Neurological** | | | |
| Pedal edema | | Dizziness | | | |
| Shortness of breath | | Fainting | | | |
| Fast heart beat | | Headaches | | | |
| Varicose veins | | Memory loss | | | |
| | | Numbness | | | |
| **Respiratory** | | Tremor | | | |
| Cough | | Vertigo | | | |
| Shortness of breath | | Weakness | | | |
| Exposure to TB | | Nervousness | | | |
| Hemoptysis | | Depression | | | |
| Wheezing | | | | | |
| | | **Hematological / Lymphatic** | | | |
| **Gastrointestinal** | | Easy Buising | | | |
| Abdominal pain | | Excessive bleeding | | | |
| Acid reflux | | History of blood transfusion | | | |
| Anorexia | | History of Leukemia | | | |
| Bloating | | | | | |
| Difficulty swallowing | | **Endocrine** | | | |
| Constipation | | Hair loss | | | |
| Diarrhea | | Heat/cold intolerance | | | |
| Heartburn | | Increased skin pigmentation | | | |
| Hemorrhoids | | | | | |
| Nausea | | | | | |
| Vomit | | | | | |

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**Please answer the following questions by circling either YES or NO**

| | | |
|---|---|---|
| Can you produce tears? | YES | NO |
| Can you produce saliva? | YES | NO |
| Do you have a history of bald spots? | YES | NO |
| Have you lost more than one quarter of hair in the last 3 months? | YES | NO |
| Do you get recurrent or prominent facial rash? | YES | NO |
| Do you get recurrent body rash? | YES | NO |
| Have you lost more than 10% of your weight in the last 6 months? | YES | NO |
| Do you get rash after being exposed to the sun? | YES | NO |
| Do your fingers beco me blanching white or purple when cold? (If only the finger tips, please answer no) | YES | NO |
| Do you have open sores on the roof of your mouth? | YES | NO |
| Do you have any open sores inside your nose? | YES | NO |
| Do you have daily joint swelling? | YES | NO |
| Do you repeatedly have a fever over 102º? | YES | NO |
| Do you have fatigue most days of the week? | YES | NO |

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**Please mark which symptoms you have experienced most in the last week**

| | |
|---|---|
| Depression | |
| Anxiety or Stress | |
| Interrupted Sleep | |
| Snoring | |
| Debilitating Headache | |
| Fatigue | |
| Crying Spells | |
| Exercise on a regular basis | |
| Mood Swings | |
| Memory Loss | |
| Brain Fog | |
| Difficulty with concentration | |
| Dizziness | |
| Numbness or Tingling | |
| Abdominal Pain | |
| Diarrhea | |
| Constipation | |