"And the afflicted thou wilt save . . ."

Allergy & Rheumatology Associates, LLC

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Name: ____________________ **Date:** __________

Past Personal History: Do you or have you had: (mark any that apply)

☐ Thyroid Problems
☐ Heart Problems
☐ High Cholesterol
☐ High Blood Pressure
☐ Stroke
☐ Pneumonia
☐ Liver Disease
☐ Connective Tissue disease
☐ Headaches
☐ Diabetes
☐ Heart disease
☐ Asthma
☐ Depression
☐ Kidney disease
☐ Immune disease
☐ Epilepsy
☐ Anxiety
☐ Gastric disease
☐ Rheumatoid Arthritis
☐ Cancer
☐ Menta
☐ Lung disease

Past Surgical History: Please specify the procedure and the date.

Procedure: __________ Date: __________ Procedure: __________ Date: __________
Procedure: __________ Date: __________ Procedure: __________ Date: __________
Procedure: __________ Date: __________ Procedure: __________ Date: __________
Procedure: __________ Date: __________ Procedure: __________ Date: __________

Any previous fractures or serious injuries? ☐ YES ☐ NO Describe: ____________________

Allergies to meds, food, environmental: ☐ YES ☐ NO Describe: ____________________

Family History:

Father: Deceased ☐ YES ☐ NO Diseases: ____________________
Mother: Deceased ☐ YES ☐ NO Diseases: ____________________
Brothers/Sisters Diseases: ____________________

Social History:

Married: ☐ YES ☐ NO Divorced: ☐ YES ☐ NO Separated: ☐ YES ☐ NO Widowed: ☐ YES ☐ NO
Smoking: ☐ YES ☐ NO If yes, how long: __________ How much per day: __________
Caffeine: ☐ YES ☐ NO If yes, how long: __________ How much per day: __________
Alcohol: ☐ YES ☐ NO If yes, how long: __________ How much per day: __________
Drugs: ☐ YES ☐ NO If yes, how long: __________ How much per day/Type: __________
On disability: ☐ YES ☐ NO Since when: __________ Profession: __________

Current Medications/Supplements List:

Name: ______________________________ Strength:______________ How Often: _________________

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Name: ______________________________ Strength:______________ How Often: _________________

Name: ______________________________ Strength:______________ How Often: _________________

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