Advanced Arthritis and Rheumatology Center

17100 Norwalk Blvd, Cerritos, CA 90703

BRIEF HISTORY FORM

Please take a moment to fill out the following forms as thoroughly as possible.

Patient Name:______________________________ Date of Birth:__________ Age:_______

Mailing Address:________________________________ Email: ____________________

City:______________________State:______________Zip:____________

Home phone:_______________ Cell phone: ______________Work Phone______________

Sex:______ Marital Status: __________________ Social Security Number: ______________

Primary Care Physician:______________________ Phone number:____________________

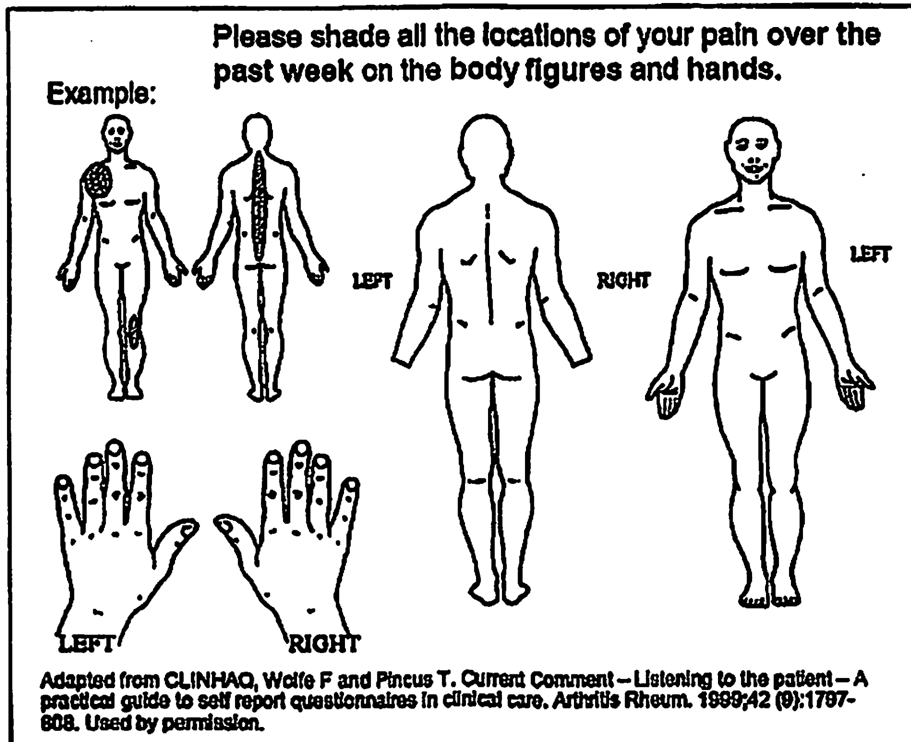
Referring Physician: _________________________Phone number: ___________________

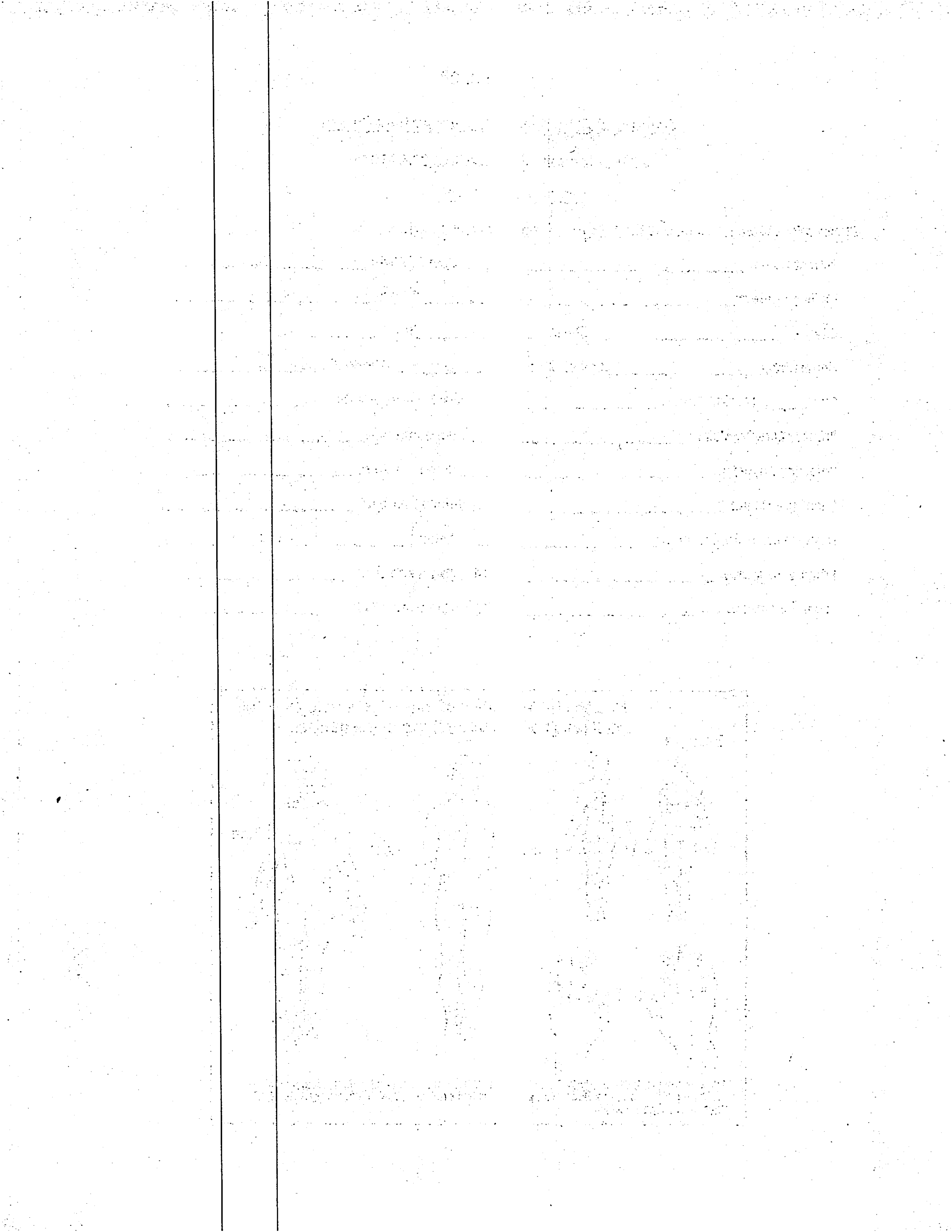
Pharmacy Name: ____________________________Phone number:____________________

Notify in case of emergency:__________________Phone: ______________Relation: _______

Primary Insurance:____________________ Insured's Name and DOB:__________________

Secondary Insurance:__________________ Insured's Name and DOB:__________________





MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Polymyalgia Rheumatia (PMR)
- ☐ Osteoporosis
- ☐ Spinal Stenosis
- ☐ Rotator Tendonitis / Tear
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Prostate Problems
- ☐ Bladder Problems ____________________
- ☐ Kidney Problems
- ☐ Sjogren's Syndrome
- ☐ ______________________________
- ☐ Last Bone Density Test? ______________
- ☐ Broken bone(s)? ______________________
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease: ____________________
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ High cholesterol
- ☐ Emphysema / Asthma
- ☐ Reflux / GERD
- ☐ Stomach/GI problems: ______________
- ☐ Depression
- ☐ Thyroid disorder
- ☐ History of tuberculosis ☐ PPD positive
- ☐ Cancer, type____________________
- ☐ ______________________________
- ☐ ______________________________
- ☐ ______________________________

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	☐ rash ☐difficulty breathing ☐ stomach pain/vomiting ☐ other:
	☐ rash ☐difficulty breathing ☐ stomach pain/vomiting ☐ other:
	☐ rash ☐difficulty breathing ☐ stomach pain/vomiting ☐ other:

SURGERIES

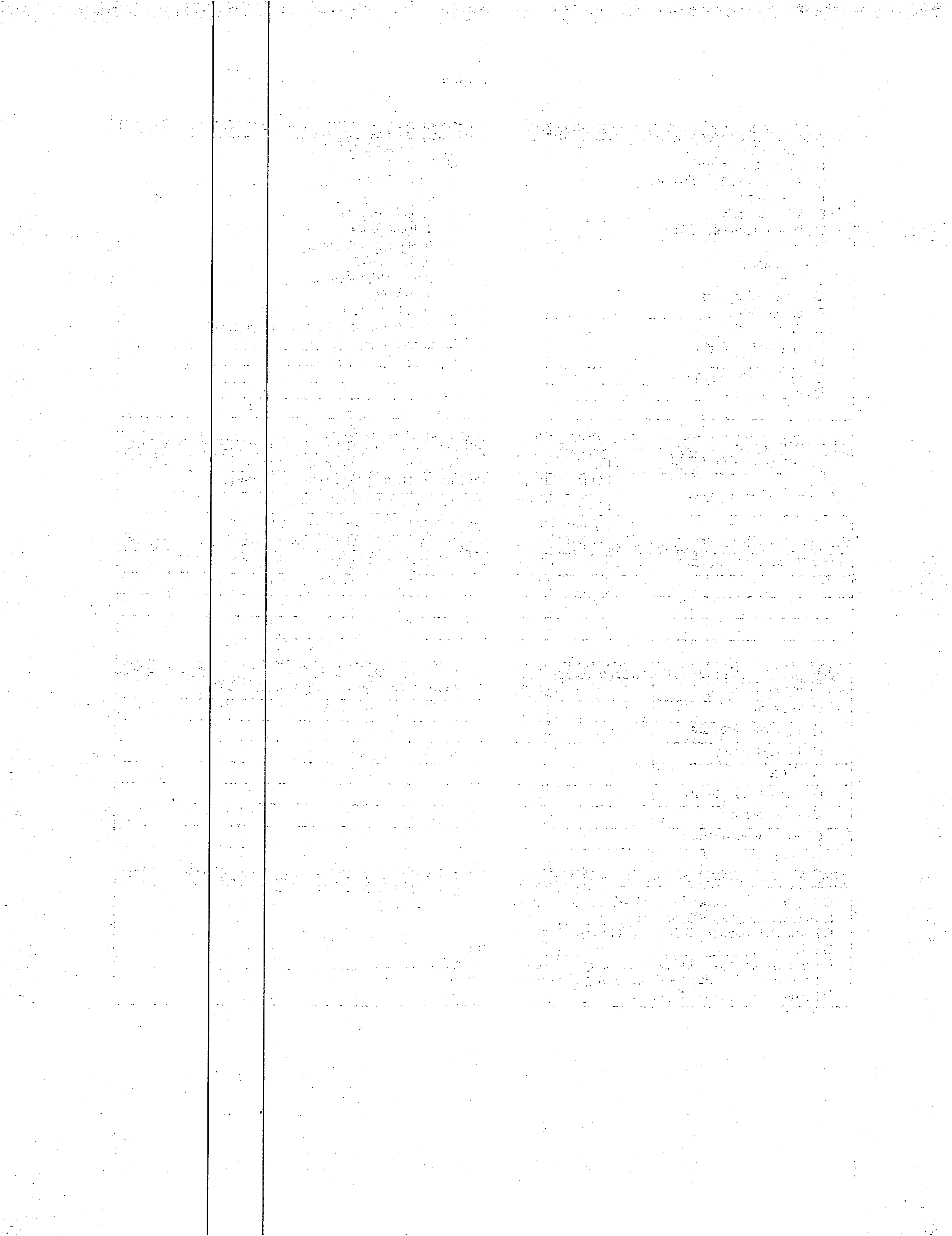
TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	*Family Members affected and exact nature of problems*
☐ Diabetes	
☐ High Blood Pressure	
☐ Heart Problems	
☐ Cancer	
☐ Rheumatoid arthritis	
☐ Osteoporosis	
☐ Parental hip fracture?	
☐ Other	

SOCIAL HISTORY / HABITS

☐ Smoking: _____ packs/day ☐ Non-smoker ☐ Quit smoking in ______
☐ Alcohol use: ☐ Yes (drinks/week:______________) ☐ No
☐ Married ☐ Widowed ☐ Divorced ☐ Single
☐ Occupation: ______________________________ ☐ Retired
☐ I exercise regularly ☐ I exercise rarely ☐ I do not exercise ☐ Type exercise ____________________
☐ I have traveled outside the United States in the past three months
☐ Recreational drug use. Type: ______________________ ☐ Never



CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)

Name of Medication **Dose** **How often taken** **Start Date** **Stop Date**

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

*use an additional sheet of paper if necessary

Please fill out following if applicable

Date of last procedure	Place where done	Date when done
Eye exam for Plaquanil		
Chest X-ray		
MRI/CT scan (Rheum. Related)		
Bone Density		
TB/PPD skin test		
Colonoscopy/Guiac stool exam		
Mammogram		

Patient Signature: ____________________ **Date:** __________

Dr. Dipti Doshi M.D.: ____________________ **Date:** __________