

**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: \_\_\_\_\_

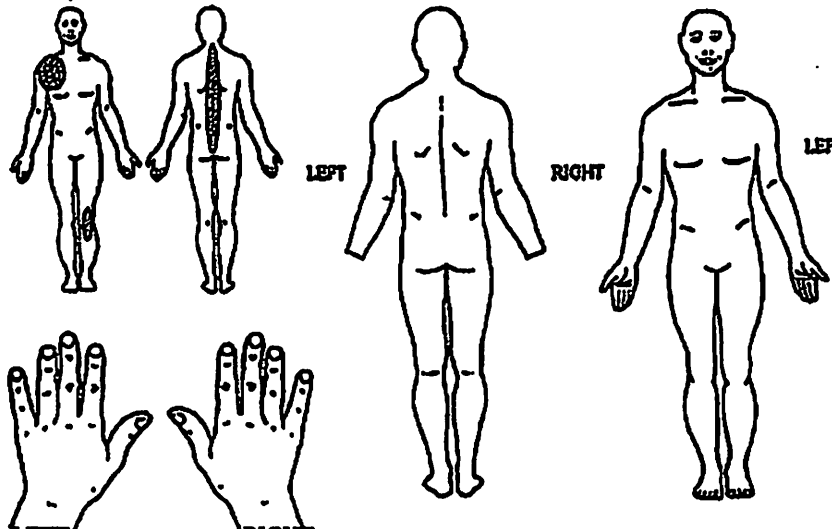
Notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Insured's Name and DOB: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ Insured's Name and DOB: \_\_\_\_\_

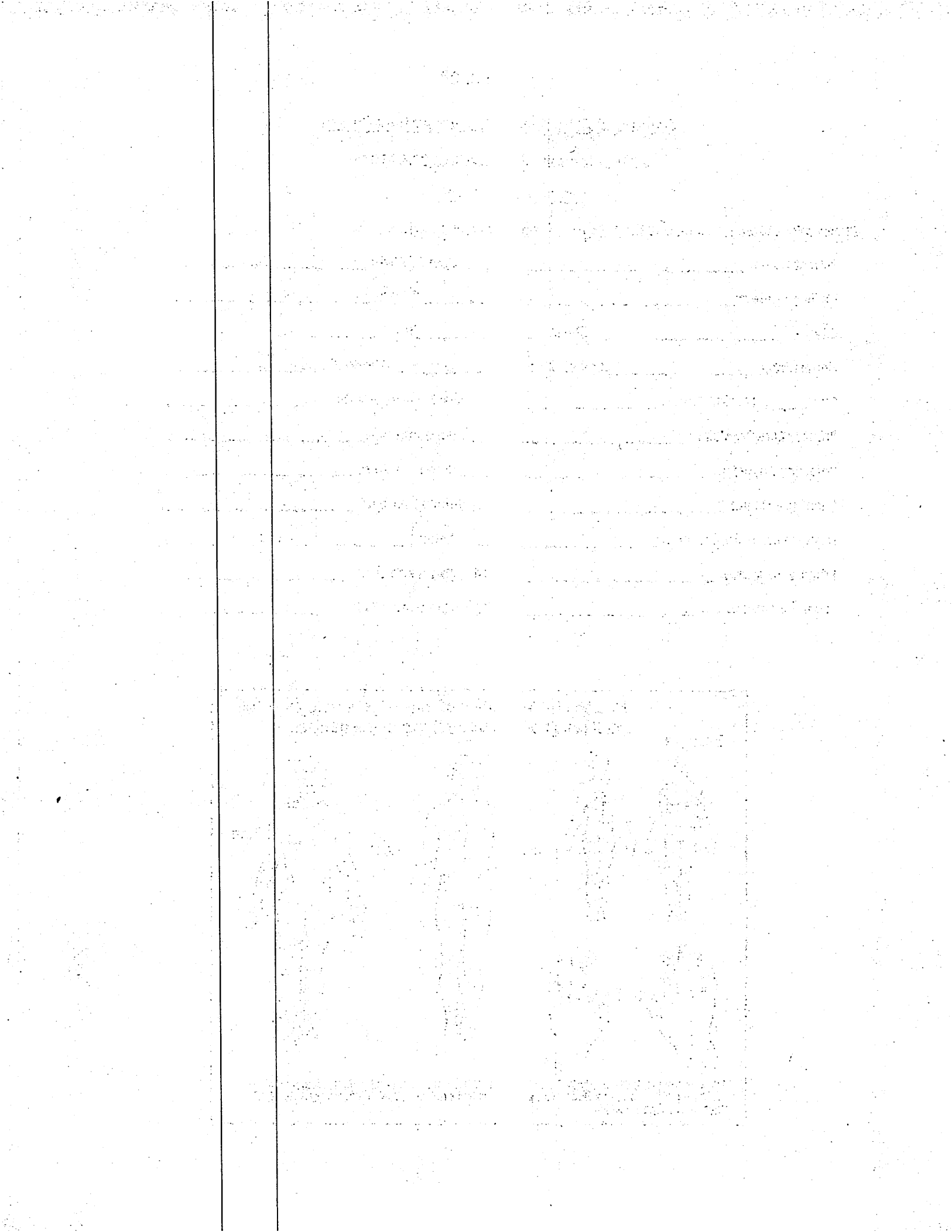
**Please shade all the locations of your pain over the past week on the body figures and hands.**

**Example:**



The diagram illustrates a patient's body and hands with shaded areas indicating pain locations. It includes four body figures: a front view of the upper body, a back view of the upper body, a full front view, and a full back view. The full front and back views are labeled 'LEFT' and 'RIGHT' respectively. Below the body figures are two hand diagrams, also labeled 'LEFT' and 'RIGHT'. The shaded areas include the right shoulder, right knee, right hand, and various points on the back and neck.

**Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.**



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

<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Polymyalgia Rheumatica (PMR) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Rotator Tendonitis / Tear <input type="checkbox"/> Bursitis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Bladder Problems _____ <input type="checkbox"/> Kidney Problems _____ <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> _____ <input type="checkbox"/> Last Bone Density Test? _____ <input type="checkbox"/> Broken bone(s)? _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease: _____ <input type="checkbox"/> Heart Attack <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> High cholesterol <input type="checkbox"/> Emphysema / Asthma <input type="checkbox"/> Reflux / GERD <input type="checkbox"/> Stomach/GI problems: _____ <input type="checkbox"/> Depression <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> History of tuberculosis <input type="checkbox"/> PPD positive <input type="checkbox"/> Cancer, type _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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**MEDICATION ALLERGIES**

NAME OF MEDICATION	TYPE OF REACTION
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other:
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other:
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other:

**SURGERIES**

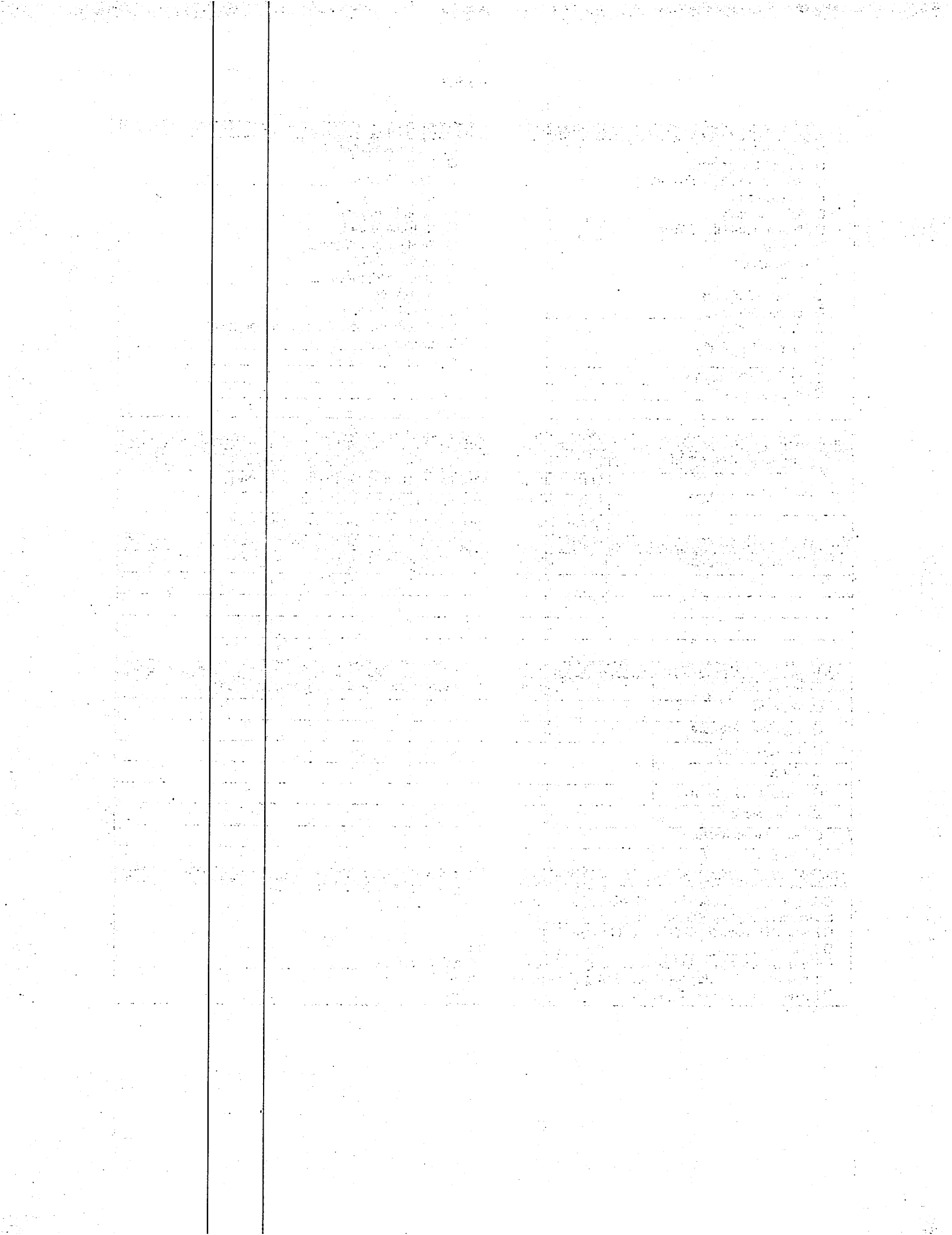
TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

**FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)**

Conditions/Problems	Family Members affected and exact nature of problems
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Problems	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Parental hip fracture?	
<input type="checkbox"/> 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/Gulac stool exam		
Mammogram		

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Dipti Doshi M.D.: \_\_\_\_\_

Date: \_\_\_\_\_

