ANNAPOLIS RHEUMATOLOGY LLC.

Primary Care Physician

(Dr's full name, Office Address; and Phone#)

NAME: ______________________

Today's Date: ______________________

Daytime Phone: ______________________

Personal History

Age: ________ Years

Occupation: ______________________

** Allergies: ______________________

Medication(s) Name	Dose	How Often Taken	Months/Years Taken

AVE PER DAY Alcohol: ____________ Tobacco: ____________ Caffeine: ____________

PAST MEDICAL HISTORY:

List your major illnesses/medical conditions:

(arthritis, cancer, diabetes, heart disease, hypertension,etc)

FAMILY HISTORY

List diseases/medical conditions of blood relatives:

Previous Sugeries (and Dates)

Arthritis or Connective Tissues Disease:

GENERAL

Fatigue	Yes	No
Marked Weight Change	Yes	No
Night Sweats	Yes	No
Persistent Fever	Yes	No
Sensitivity to Cold	Yes	No

SKIN

Skin Rash	Yes	No
Hair Loss/thinning	Yes	No
Change in nails	Yes	No
Reaction to sun	Yes	No
Psoriasis	Yes	No
Tightening of Skin	Yes	No

EYES

Vision Changes	Yes	No
Eye pain	Yes	No
Red eyes	Yes	No
Dry eyes	Yes	No

EARS

Loss of hearing	Yes	No
Ringing in ears	Yes	No

NOSE

Nosebleeds (frequent)	Yes	No
Persistent congestion	Yes	No

MOUTH

Mouth sores	Yes	No
Pain in chewing	Yes	No
Dry mouth	Yes	No

CARIO-RESPIRATORY SYSTEM

Persistent cough	Yes	No
Pain in breathing	Yes	No
Shortness of breath	Yes	No
Heart Murmur	Yes	No

GASTEROINTESTINAL

Loss of Appettite	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Nausea or vomiting	Yes	No
Diarrhea	Yes	No
Stomach Ulcer	Yes	No

ENDOCRINE

Diabetes	Yes	No
Thyroid disease	Yes	No

NERVOUS SYSTEM

Chronic headaches	Yes	No
Memory loss	Yes	No
Seizures	Yes	No
Numbness/tingling	Yes	No
Weakness/paralysis	Yes	No

GENITOURINARY

Blood in Urine	Yes	No

OB-GYN

Number of preganancies: ____________________

Number of miscarriages: ____________________

Hysterectomy	Yes	No
Hormone Replacement	Yes	No