Arthritis & Joint Center of Florida
2328 Medico Lane Melbourne, FL 32940
321.956.1501 fax 321.956.1502

PATIENT MEDICAL HISTORY

Height: __________________________ Weight: __________________________

Patient Name ____ Today's Date_______________________

Date of Birth ____

Describe Problem ____

Primary Care Doctor____

Cardiologist Doctor____

Pulmonologist Doctor ____

Pharmacy ____

Previous Surgeries/Year Done:

____

____

____

Current Medications: ☐ NO MEDICATIONS USED

____

____

____

____

List Allergies to Medications:

____

____

Are you currently under pain management? Yes No Provider: _____________________________________

Current Living Situation: ___ Alone ___ w/Spouse ____ w/Family ____ w/Friend

Do you use alcohol/drugs? Yes No How often? ______________________________________

Tobacco Use (circle one)? Every Day Occasionally Never
Former Smoker (Dates: from _________ to __________)

Vaping w/ Nicotine (circle one) ? Every Day Occasionally Never

******** **Please turnover for additional info-→**

PAST MEDICAL HISTORY : (check all that apply)

____ Anemia	____ Blood Clot	____ Diabetes	____ High Cholesterol
____ Anxiety/Depression	____ Blood Transfusion	____ Gout	____ HIV or AIDS
____ Arthritis	____ Cancer	____ Heart Attack (MI)	____ Hypertension
____ Asthma	____ COPD	____ Heart Problems	____ Kidney Disease
____ Bleeding Disorder	____ Coronary Artery Disease	____ Hepatitis	____ Liver Disease
____ Migraines	____ Orthotics	____ Osteoporosis	____ Peripheral Vascular Disease
____ Pulmonary Embolism	____ Rheumatoid Arthritis	____ Seizures/Epilepsy	____ Sleep Apnea
____ Stroke	____ Thyroid Problems	____ Tuberculosis	____ Ulcers

REVIEW OF SYSTEMS (**Please check all that apply)**

CONSTITUTIONAL: ☐ FEVER/CHILLS ☐ NIGHT SWEATS ☐ WEIGHT GAIN ☐ WEIGHT LOSS ☐ EXERCISE INTOLERANCE

CARDIOVASCULAR: ☐ CHEST PAIN ☐ ARM PAIN ON EXERTION ☐ CHEST PAIN ON EXERTION ☐ SHORTNESS OF BREATH WHEN WALKING ☐ SHORTNESS OF BREATH WHEN LYING DOWN ☐ PALPITATIONS ☐ KNOWN HEART MUMUR ☐ LIGHT-HEADED ON STANDING

RESPIRATORY: ☐ COUGH ☐ WHEEZING ☐ SHORTNESS OF BREATH ☐ COUGHING UP BLOOD ☐ SLEEP APNEA

MUSCULOSKELETAL: ☐ MUSCLE ACHES ☐ MUSCLE WEAKNESS ☐ ARTHRALGIAS/JOINT PAIN ☐ BACK PAIN ☐ SWELLING IN THE EXTREMITIES

NEUROLOGIC: ☐ LOSS OF CONSCIOUSNESS ☐ WEAKNESS ☐ NUMBNESS ☐ SEIZURES ☐ DIZZINESS ☐ HEADACHES ☐ MIGRAINES ☐ RESTLESS LEGS