Arthritis & Joint Center of Florida
2328 Medico Lane Melbourne, FL 32940
Ph) 321-956-1501 Fax 321-956-1502

PATIENT MEDICAL HISTORY

FOR OFFICE USE ONLY

Height: _____ Weight: _____ BMI: _____

Assistant Reviewing Data/Date: _____

_____

Patient Name _____ Today's Date_____

Date of Birth _____ Age _____

Describe Problem _____

Name of Primary Care Doctor _____

Previous Surgeries/Year Done:

_____

_____

_____

_____

Major Past/Present Illnesses:

_____

_____

_____

_____

List Allergies to Foods/Medications

_____

_____

_____

Do you have a pacemaker? Yes No

Are you claustrophobic? Yes No

Are you currently under pain management? Yes No

Do you use alcohol/drugs? Yes No

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

Are you pregnant (circle one)? Yes No

Are you nursing (circle one)? Yes No

Provider: _____

How often? _____

(please complete reverse side of form also)

Medical Conditions

	(Check One)			Any Medication(s) Currently Taken for This Condition			
	Yes	**No**	**Doctor**	**Drug**	**Dose**	**Frequency**	***Office Use***
Anemia							
Anxiety/ Depression							
Arthritis							
Asthma							
Bleeding Disorder							
Blood Clot							
Blood Transfusion							
Cancer							
COPD							
Coronary Artery Disease							
Diabetes							
Gout							
Heart Attack (MI)							
Heart Problems							
Hepatitis (specify type)							
High Cholesterol							
HIV or AIDS							
Hypertension							
Kidney Disease							
Liver Disease							
Migraines							

Orthotics							
Osteoporosis							
Peripheral Vascular Disease							
Pulmonary Embolism							
Rheumatoid Arthritis							
Seizures/Epilepsy							
Sleep Apnea							
Stroke							
Thyroid Problems							
Tuberculosis							
Ulcers							

_____ _____

Patient Signature Date