SOUTHERN TIER ARTHRITIS & RHEUMATISM
JAMES C. VANDEWALL, M.D.
JOSEPHINE RAAB, ANPC
DOUGLAS E. TANNER, RPAC
MEDICAL HISTORY FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____

ILLNESS (other than childhood diseases): _____

_____

_____

SURGERIES: _____

_____

_____

_____

_____

SERIOUS INJURIES: _____

_____

_____

HAVE YOU IN THE PAST OR DO YOU CURRENTLY:

SMOKE OR CHEW TOBACCO? _____ IF YES, HOW LONG? _____HOW MUCH? _____

DO YOU DO EITHER OF THE FOLLOWING:

DRINK ALCOHOL? _____ IF YES, HOW MUCH? _____

USE OTHER DRUGS? _____ IF YES, DESCRIBE USAGE, TYPE, HOW MUCH? _____

_____

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? _____

WHAT ARE THE CURRENT HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? _____

_____

ALLERGIES (to medication or food)? _____

_____