TANNER CLINIC

Medical History Form

Name:____________________________ Date of Birth:___________________________________

Referring Doctor:___________________ Primary Care Doctor:____________________________

Allergies:____

____

Medications (name, dose, frequency)

1.___________________________________ 2.____

3.___________________________________ 4.____

5.___________________________________ 6.____

7.___________________________________ 8.____

9.___________________________________ 10.____

11.__________________________________ 12.____

13.__________________________________ 14.____

Surgeries:

____

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Past Medical History

Have you had any of the following?

Diabetes	Yes	No
Cancer	Yes	No
Kidney disease	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Coronary artery disease	Yes	No
Osteoporosis	Yes	No
Osteoarthritis	Yes	No
Blood clots	Yes	No
COPD/Asthma	Yes	No

Other: please list: ___________________

Family History

Has any first degree relative had any of the following?

Rheumatoid Arthritis	Yes	No
Lupus	Yes	No
Ankylosing Spondylitis	Yes	No
Psoriasis	Yes	No
Psoriatic Arthritis	Yes	No
Crohn's Disease	Yes	No
Ulcerative Colitis	Yes	No

Social History

Tobacco use	Yes	No
Consume alcohol	Yes	No
Illicit drug use	Yes	No

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Review of Systems

Please indicate if you have had any of these in the last 2-3 weeks:

- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Cough
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Ankle swelling
- ☐ Abdominal pain
- ☐ Blood in the stool
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea or vomiting
- ☐Pain with urination
- ☐ Blood in the urine
- ☐ Weakness in an extremity
- ☐ Numbness in an extremity
- ☐ Anxiety
- ☐ Alopecia (patchy hair loss)
- ☐ Facial rash
- ☐ Photosensitive rash
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Morning stiffness
- ☐ Easy bruising
- ☐ Double vision
- ☐ Finger nail changes