Catalina Pointe
Arthritis & Rheumatology Specialists, PC

Name: _____ Birthdate: _____/_____/_____
Last First Middle Int. Month/Day/Year

Phone: Home ( )_____Cell: ( ) _____ Wk: ( ) _____

Referred here by: Dr. _____ Family/Friend _____ Other _____

Highest level of education: _____

Name of primary care physician: _____ Office phone: ( ) _____

Please list the names of previous Rheumatologist(s): _____

_____

Please list your health problems, surgeries, and/or hospitalizations:

Health Problems	Surgeries	Hospitalizations

Please list your current medications (if you need more space, please use back of page):

Medication	Dose	How Often	Medication	Dose	How Often
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you smoke? Yes No If yes, how much per day and for how long? _____

Do you drink alcohol? Yes No If yes, how much and how often? _____

Date of last eye exam: ____ /____/_____ Date of last Tuberculosis skin test: _____/_____/_____

Date of last bone density scan: _____/_____/_____ Date of last chest x-ray: _____/_____/_____

Do you have any medical allergies? Yes No If yes, please list: _____

_____

Do you take any natural or alternative therapies or over-the-counter preparations? Yes No

If yes, please list:_____

_____

Have you participated in any medication clinical trials/studies? Yes No

If yes, please list: _____

Thank you for completing this form. We look forward to participating in your care.

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