Arthritis and Rheumatology Clinical Center of Northern Virginia, PLLC

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History Form

Date/Fecha: ____/_____/_____

Name/Nombre:_____
Last/Apellido First/Primer Nombre

Birthdate/Fecha de Nacimento: ____/_____/_____ **Age**/Años_____ **Sex**/Sexo: F M

Name of your primary care Physician/ Nombre de su Médico de Atención Primaria:_____
Name of referring Physician/Nombre del médico refiriéndose:_____
Occupation/profesión:_____

Why are you here today (your main complaint)? Por qué estás aquí hoy (su queja principal)?

_____

When did your symptoms start? Cuando comenzaron los síntomas?

_____

What diagnosis have you been given? Qué diagnóstico le han dado a usted?

_____

Previous treatment for this problem (physical therapy, surgery, or injections) Tratamiento previo para este problema (fisioterapia, cirugía o inyecciones)

_____

Medications and Supplements/ Medicamentos y suplementos: Please list any medications that you are now taking, Include non-prescription, such as aspirin, vitmains, glucosamine, laxatives, calcium, etc.

Name of Drug Dose Nombre del medicamentos	**(dose and number of pills per day)** Dosis y número de tabletas
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Drug allergies/Alergias a medicamentos: No, if Yes what Medications?_____
_____

Past Medical History/historial medico:

_____
_____

Previous Operations/Cirugías previas:

_____
_____

Family History/historia familiar:

	IF LIVING/vivo		IF DECEASED/ fallecido	
	Age /años	Health/salud	Age of death	Cause
Father/Padre				
Mother/Madre				

Children/Hijos: Yes or No

Social History/historia social:

- Do you smoke? *Usted Fumas?* YES or NO
  In the past? _____ How long ago?_____

- Do you drink alcohol? Bebes alcohol? NO or YES
  If yes, Socially or Daily

- Do you use drugs for reasons that are not medical? ¿Utiliza drogas por razones que no son médicas?
  NO or YES
  If yes, please list:_____

Immunization History/ Historia de vacunación:

Flu Shot Flu de vacuna?	
Pneumonia Shot neumonía de vacuna?	
Zoster/Shingle Shot	