SCOTT T. KAWAMOTO, M.D., LLC ▪ RHEUMATOLOGY

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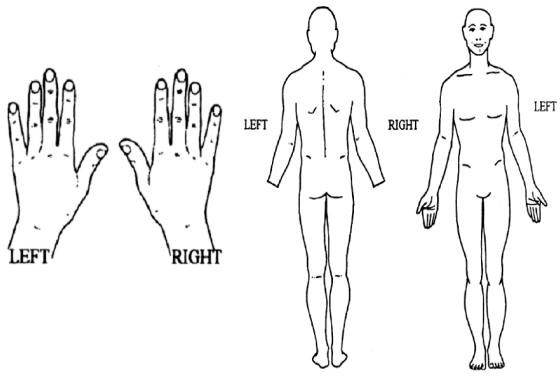
Legal Name (Last) (First) (Middle)	Date of Birth / /	□ F □ M
Referring Physician	Other Physicians	

HISTORY OF PRESENT ILLNESS

Briefly describe your present symptoms:_____

Mark all locations of your present symptoms:



Date symptoms began: _____

Previous treatment and outcomes (include names of medications, injections, surgery, physical therapy and other modalities): □ None

PAST MEDICAL AND SURGICAL HISTORY

Do you now or have you ever had: □ None

N	Y		N	Y	
□	□	High blood pressure	□	□	Esophageal reflux
□	□	High cholesterol	□	□	Peptic ulcer disease
□	□	Diabetes	□	□	Kidney disease
□	□	Heart disease (specify)	□	□	Liver disease
		_____	□	□	Thyroid disease
□	□	Stroke	□	□	Osteoporosis
□	□	TIA	□	□	Osteopenia
□	□	Seizure	□	□	Psoriasis
□	□	Migraine headache	□	□	HIV/AIDS
□	□	Asthma	□	□	Hepatitis
□	□	COPD/emphysema	□	□	Tuberculosis
□	□	Other lung disease	□	□	Depression
□	□	Anemia	□	□	Anxiety
□	□	Cancer (specify)	□	□	Cataract
		_____	□	□	Glaucoma

List all other illnesses:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all previous operations: □ None

Type of surgery	Date

For women: Last menstrual period: / / Last mammogram: / / Last pap/pelvic exam: / /

No. of pregnancies: _____ Children born alive: _____ Miscarriages: _____ Abortions: _____ Pregnancy complications: _____

Last TB test: □ Neg □ Pos / /	Last influenza vaccine: / /	Last pneumonia vaccine: / /	Last colonoscopy: / /

List all other hospitalizations or serious injuries unrelated to the above: □ None

Legal Name (Last) (First) (Middle)

MEDICATIONS

List all current medications: □ None
Include name, dose, and frequency, if known

1. _____ 11. _____
2. _____ 12. _____
3. _____ 13. _____
4. _____ 14. _____
5. _____ 15. _____
6. _____ 16. _____
7. _____ 17. _____
8. _____ 18. _____
9. _____ 19. _____
10. _____ 20. _____

ALLERGIES

Allergies to medications and food: □ None

Name Reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

FAMILY HISTORY

□ Unknown	**If living**	**If deceased**
	Age Medical problems	Age Cause of death
Father		
Mother		
Siblings		
Children		

Do you know of any blood relative who has or had: (check box and indicate relationship) □ None

□ Arthritis (unknown type) _____
□ Osteoarthritis _____
□ Rheumatoid arthritis _____
□ Ankylosing spondylitis _____
□ Psoriasis _____
□ Inflammatory bowel disease _____
□ Lupus or SLE _____
□ Gout _____
□ Childhood arthritis _____
□ Osteoporosis _____
□ Fibromyalgia _____
□ Other _____

SOCIAL HISTORY

Marital Status:
□ S □ M □ D □ W

Occupation:

Employer:

Do you smoke? □ No □ Yes □ Quit
If yes/quit, _____ packs per day for _____ years

Do you drink alcohol? □ No □ Yes □ Quit
If yes/quit, how much?

Have you ever used illicit drugs? □ No □ Yes □ Quit
If yes/quit, type and last use?

Do you exercise regularly? □ No □ Yes
If yes, type and frequency?

Patient Signature: Date: