Covina Arthritis Clinic

HEALTH QUESTIONNAIRE

Name: _____

Date of Birth:_____**Age:**_____**Sex:**_____**Marital status:**_____

Reason for Referral:_____

Describe briefly your present symptoms: _____

_____

Date symptoms began (approximate): _____**Diagnosis given? (Please list)**:_____

_____

Previous treatment for this problem: _____

_____

Past Medical History: _____

_____

Previous Operations: _____

_____

Your Occupation: _____

Social History

Smoking (Amt): _____

Drinking (Amt): _____

Others drugs: _____

Family History:

Current Age Health Problems Age & Cause of Death

Father: _____

Mother: _____

Siblings:

Brothers & Sisters: _____

Children:

Boys & Girls: _____

Drug Allergies & Reaction: **Yes** **No** if **Yes**, to what? _____

Type of reaction: _____

500 West San Bernardino, Rd,STE A. Covina, Ca 91722
Tel (626-966-1909 Fax (626) 209-0331
www.covinaarthritisclinic.com

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Medication List

Medication list	Dose/Strength (mg)	Number of pills/tabs	Times per day

Thank you for your time, we look forward to seeing you…

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