



LivWell Rheumatology

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Past Medical History

Patient Name: _____ Date: _____

Surgeries:	Approx. Date:

Hospitalizations for Illness:	Approx. Date:

List any medical conditions past or present:

Current Medications:

Allergies:

Social History:	
Birthplace:	
Ethnic Origin:	Education:

Social History Continued:	
Do you smoke?	If yes, how long?
How many per day?	Interested in quitting?
Do you drink alcohol?	If yes, how often?
How many drinks, when you do drink alcohol?	
Do you use any recreational drugs?	
Do you use any prescription drugs recreationally?	

Family Medical History:	
Father's Age:	Alive or Deceased?
List any medical conditions:	
Mother's Age:	Alive or Deceased?
List any medical conditions:	
How many brothers?	How many sisters?
List any medical conditions:	
How many daughters?	How many sons?
List any medical conditions:	
Has any relative, living or deceased, ever had any of the following:	
Diabetes:	Heart Disease:
Hypertension:	Stroke:
Blood disorders:	Crohn's Disease:
Ulcerative Colitis:	Ulcers:
Osteoarthritis:	Chronic Back Pain:
Rheumatoid Arthritis:	Ankylosing Spondylitis:
Psoriasis:	Lupus:
Gout:	Scleroderma:
Reiter's Syndrome:	Birth Defects:
Inherited or Congenital Bone/Joint Disease:	
Other:	