Arthritis Medical Clinic

Osteoporosis Diagnostic Imaging & Treatment Center

6180 Brockton Ave, Suite 204 • Riverside, California 92506

(951) 781-7700 • FAX (951) 781-0313

HEALTH QUESTIONNAIRE

Name_____ Date_____

Complete the questionnaire as much as possible. This will remain a confidential part of your medical record.

1. **Visit Reason?** ☐Abnormal Labs ☐Joint Pain ☐Other:_____

2. **Health History** (Check all that apply)

☐ Anxiety	☐ Diabetes (Type 1 or 2)	☐ Kidney Stones	☐ Stomach Ulcers
☐ Thyroid Disease	☐ Blood Pressure	☐ Liver Disease	☐ High Cholesterol
☐ Depression	☐ Kidney Disease	☐ Stroke (Date:_____)	
☐ Thyroid Disease	☐ Heart Stent/Bypass (Date:_____)		

☐ Heart Attack (Date:_____)

☐ Cancer (Type: _____ Date of last treatment_____)

3. **History of surgery?** Yes or No. *If yes, please list:*_____

_____

4. **Allergies:** ☐ Sulpha Drugs ☐ Vaccines ☐ Antibiotics (list them):_____ ☐ Other_____

_____

5. **Personal/ Social History:**

Marital (check one): ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Menstrual & Pregnancy History (Females) *Spontaneous Miscarriage*_____

Your Occupation _____

6. **Personal Habits:**

Tobacco: ☐ Past (Year Stopped_____) ☐ Current Use (Packs per day:_____) ☐ Never

Alcohol: ☐ Less than once weekly ☐ Once Weekly or More ☐ Never

Recreational Drug Use: ☐ Marijuana ☐ CBD ☐ Other_____ ☐ Current Use ☐ Past Use

7. **Family History:** Mother ☐ alive ☐ deceased Father ☐ alive ☐ deceased

☐ Cancer	☐ Kidney Disease	☐ High Blood Pressure	☐ Heart Disease
☐ Osteoporosis	☐ Bleeding Problem	☐ Strokes	☐ Diabetes

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Nazee Farsi, MD
Nayef Kazzaz, MD
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ARTHRITIS MEDICAL CLINIC

Please check which symptoms you have experienced in the last seven days.

Constitutional		**Genitourinary**		**Allergic/Immunologic**	
Chills		Dysuria		Seasonal allergies/hayfever	
Fatigue		Genital lesions		Itching and skin rash	
Fever		Blood in urine			
Night sweats		Frequent urination at night		**Psychiatric**	
Wweight gain (unintentional)		Frequent urination		Anxiety	
weight loss (unintentional)				Crying spells	
		Musculoskeletal		Depression	
Eyes		Joint pain		Feel stressed	
Blurry vision		Back pain		Loss of interest in pleasurable activity	
Eye drainage		Joint stiffness		Poor concentration	
Eye pain		Limb pain		Recreational drug use	
Dry eyes		Muscle pain		Sadness	
Sensitivity to light		Weakness		Sleep disturbance	
		Poor ambulation		Suicidal thoughts	
Ears/ Nose/Throat		Deformities			
Difficulty swallowing		Swelling			
Dry Mouth					
Nosebleed		**Skin**			
Non-healing nasal ulcer		Dry skin			
Bleeding Gums		Itching			
Sore/Ulcer in mouth		Rashes			
Sore tongue		Ulcerations			
		Sun sensitivity			
Cardiovascular		Color changes			
Chest pain					
Palpitations		**Neurological**			
Pedal edema		Dizziness			
Shortness of breath		Fainting			
Fast heart beat		Headaches			
Varicose veins		Memory loss			
		Numbness			
Respiratory		Tremor			
Cough		Vertigo			
Shortness of breath		Weakness			
Exposure to TB		Nervousness			
Hemoptysis		Depression			
Wheezing					
		Hematological / Lymphatic			
Gastrointestinal		Easy Buising			
Abdominal pain		Excessive bleeding			
Acid reflux		History of blood transfusion			
Anorexia		History of Leukemia			
Bloating					
Difficulty swallowing		**Endocrine**			
Constipation		Hair loss			
Diarrhea		Heat/cold intolerance			
Heartburn		Increased skin pigmentation			
Hemorrhoids					
Nausea					
Vomit					

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ARTHRITIS MEDICAL CLINIC

Please answer the following questions by circling either YES or NO

Can you produce tears?	YES	NO
Can you produce saliva?	YES	NO
Do you have a history of bald spots?	YES	NO
Have you lost more than one quarter of hair in the last 3 months?	YES	NO
Do you get recurrent or prominent facial rash?	YES	NO
Do you get recurrent body rash?	YES	NO
Have you lost more than 10% of your weight in the last 6 months?	YES	NO
Do you get rash after being exposed to the sun?	YES	NO
Do your fingers beco me blanching white or purple when cold? (If only the finger tips, please answer no)	YES	NO
Do you have open sores on the roof of your mouth?	YES	NO
Do you have any open sores inside your nose?	YES	NO
Do you have daily joint swelling?	YES	NO
Do you repeatedly have a fever over 102º?	YES	NO
Do you have fatigue most days of the week?	YES	NO

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ARTHRITIS MEDICAL CLINIC

Please mark which symptoms you have experienced most in the last week

Depression	
Anxiety or Stress	
Interrupted Sleep	
Snoring	
Debilitating Headache	
Fatigue	
Crying Spells	
Exercise on a regular basis	
Mood Swings	
Memory Loss	
Brain Fog	
Difficulty with concentration	
Dizziness	
Numbness or Tingling	
Abdominal Pain	
Diarrhea	
Constipation	