ROMANICK MD PLLC

arthritis, fibromyalgia & immune disorders

Dear Patient: Kindly complete this form so your medical history is up to date.

Name: **Age:** **Date:**

Why you came today		Please list your medications	Dose	How often
Past Medical Problems	When			
		Vitamins & Herbs	Dose	How often
Operations	When			
		Medication Allergies		Reaction
Hospitalizations & Reasons	When	Check here if none: ☐		

New patients: please fill in all sections below **Established patients**: only note changes

Habits	Amount	How Long	Other Health Habits	Yes	No	When
Tobacco			Seatbelts			
Alcohol			Tetanus Vaccine			
Caffeine			Pneumonia Vaccine (Pneumovax)			
Other Drug use			Flu Shot (annual)			
Diet Restrictions			Hepatitis Vaccines (A or B)			
Fat/Cholesterol			Tuberculosis Skin Test (PPD)			
Other			Exercise			

Personal History	
Where were you born:	
Occupation:	Education:
Exposure to toxins or chemicals, HIV, Hepatitis B or C - Circle where applicable and specify:	
Foreign travel:	Military Service:
Marital status (please circle) S M D W	

Family History	Age if living	Age of death	Health Problems
Mother			
Father			
Brothers or Sisters			
Children			