KAHN, RISKIN & SANTIAGO, MD's, P.A.

Please fill out all pages as completely as possible

Patient History

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1 SW 129th Ave #401 Pembroke Pines, FL 33027
Phone- (954) 450-8980 Fax-(954) 441-9033

Name: ______________________________ Date: __________

Social History

Age: ________ Occupation: ______________________________

Marital Status: ❑ M ❑S ❑D ❑W Number of Children ______ Ages: __________

Do You Smoke ❒ Yes ❒ No	**Do you drink alcohol?** ❒ Yes ❒ No	**Do you use street/recreational drugs?** ❒ Yes ❒ No
If Yes:	If Yes:	If Yes:
How many packs a day? ______	How much? ____________	What? ____________
How many years? __________	How often? ____________	How often? ____________
❒ Quit Date: _______	❒ Quit Date: _______	❒ Quit Date: _______
	❒ In a recovery program?	❒ In a recovery program?

Family History

Mother	Father
Living ❒ Yes ❒ No If No Age @ death __________	Living ❒ Yes ❒ No If No Age @ death __________
Medical Conditions ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	Medical Conditions ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

Do you have a family history of:

❒ Yes ❒ No Osteoporosis If Yes, Who: ______________________________
❒ Yes ❒ No Rheumatoid Arthritis If Yes, Who: ______________________________
❒ Yes ❒ No Osteoarthritis If Yes, Who: ______________________________
❒ Yes ❒ No Gout If Yes, Who: ______________________________
❒ Yes ❒ No Other Connective Tissue Disease

If Yes, What: ______________________ Who: ______________________

Medical History

Please list your medical conditions:

Hospitalizations & Surgeries - Please list all

Year	Operation / Illness	Year	Operation / Illness

Allergies - Please list any allergies to medications, foods, x-ray dyes, environmental items, adhesive tapes. *Example: Penicillin causes rash, eggs cause hives, Pollen causes sneezing*.

Allergy	Reaction

Medications (list all medications you are now taking or have taken in the last 2 weeks)

Name of Medication	Doses / Times per day	Reason for taking	How long?

Have you recently had any of the following?

GENERAL
- Fatigue ❒ Yes ❒ No
- Marked weight change ❒ Yes ❒ No
- Night Sweats ❒ Yes ❒ No
- Persistent fever ❒ Yes ❒ No
- Sensitivity to cold ❒ Yes ❒ No
- Blood Clots legs/lungs ❒ Yes ❒ No

SKIN
- Skin Rash ❒ Yes ❒ No
- Hair loss / thinning ❒ Yes ❒ No
- Change in nails ❒ Yes ❒ No
- Reaction to sun ❒ Yes ❒ No
- Psoriasis ❒ Yes ❒ No
- Tightening of skin ❒ Yes ❒ No
- Color changes to fingers ❒ Yes ❒ No

EYES
- Vision Changes ❒ Yes ❒ No
- Eye pain ❒ Yes ❒ No
- Red eyes ❒ Yes ❒ No
- Dry eyes ❒ Yes ❒ No

EARS
- Loss of hearing ❒ Yes ❒ No
- Ringing in ears ❒ Yes ❒ No

NOSE
- Frequent nose bleeds ❒ Yes ❒ No
- Persistent congestion ❒ Yes ❒ No

MOUTH
- Pain with chewing ❒ Yes ❒ No
- Mouth sores ❒ Yes ❒ No
- Dry mouth ❒ Yes ❒ No

CARDIO-RESPIRATORY SYSTEM
- Persistent Cough ❒ Yes ❒ No
- Pain on breathing ❒ Yes ❒ No
- Shortness of breath ❒ Yes ❒ No
- Heart murmur ❒ Yes ❒ No
- Chest pain ❒ Yes ❒ No

GASTROINTESINAL
- Loss of Appetite ❒ Yes ❒ No
- Difficulty Swallowing ❒ Yes ❒ No
- Heartburn ❒ Yes ❒ No
- Nausea or Vomiting ❒ Yes ❒ No
- Diarrhea ❒ Yes ❒ No
- Stomach Ulcer ❒ Yes ❒ No

ENDOCRINE
- Diabetes ❒ Yes ❒ No
- Thyroid Disease ❒ Yes ❒ No

NERVOUS SYSTEM
- Chronic Headache ❒ Yes ❒ No
- Memory loss ❒ Yes ❒ No
- Seizures ❒ Yes ❒ No
- Numbness Tingling ❒ Yes ❒ No
- Weakness / paralysis ❒ Yes ❒ No
- Stroke/ TIA ❒ Yes ❒ No

GENITOURINARY
- Blood in urine ❒ Yes ❒ No
- Kidney Stones ❒ Yes ❒ No

OB-GYN
- Number of pregnancies ___________
- Number of miscarriages ___________
- Hysterectomy ❒ Yes ❒ No
- Hormone replacement ❒ Yes ❒ No

OSTEOPOROSIS
- Height loss ❒ Yes ❒ No
- Used Prednisone ❒ Yes ❒ No
- Had fractures ❒ Yes ❒ No
- Do you take Vitamin D ❒ Yes ❒ No

If yes, how many units per day? _______

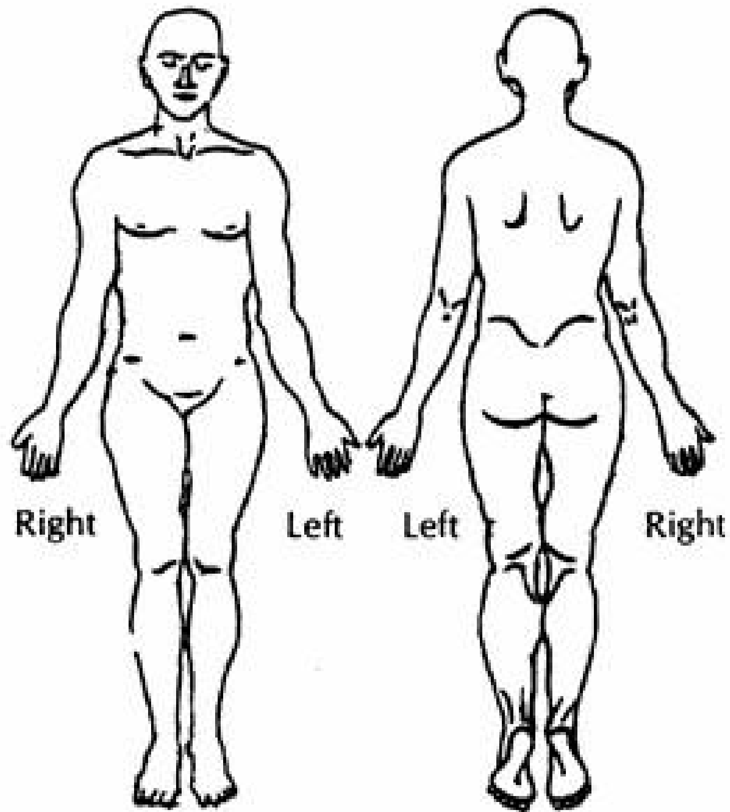
Activity – Please check the most appropriate answer

Vigorous Activity (Running, lifting heavy objects, etc)		❒ Yes Limited a little	❒ No
Moderate Activity (Pushing vacuum cleaner, playing golf, moving a table, etc.)		❒ Yes Limited a little	❒ No
Carrying / lifting groceries		❒ Yes Limited a little	
Climbing stairs		❒ Yes Limited a little	
Bending, kneeling, or stooping		❒ Yes Limited a little	
Bathing or dressing self		❒ Yes Limited a little	
Writing		❒ Yes Limited a little	
Feeding self, cutlery		❒ Yes Limited a little	
Getting out of a chair, car		❒ Yes Limited a little	
Walking one block		❒ Yes Limited a little	❒ No Not limited at all
Walking one mile		❒ Yes Limited a little	❒ No Not limited at all

Where Do You Have Pain?

Please Mark Areas Below

PAIN **(X)** SWELLING **(+)** STIFFNESS **(-)**



Where do you have pain? ______________________________

How often? ____________________ For how long? ____________________

What relieves the pain? ______________________________

What causes or increases the pain? ______________________________

Do you have swelling in your joints? ______________________________

Do you have morning stiffness? ❒ Yes ❒ No If Yes, for how long? ____________________

What time of day is the worst for your symptoms? ______________________________

Signature of Reviewing Physician: ______________________________ Date: ______________