

**ALLERGY & RHEUMATOLOGY MEDICAL CLINIC, INC.**

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Date of first appointment: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Married yes no

Referred here by: (check one)  Self  Family  Friend  Doctor  Other Health Professional

Name of person making referral: \_\_\_\_\_

The name of the person providing your primary medical care: \_\_\_\_\_

<b>What is your chief complaint?</b>
1. _____
2. _____
3. _____
4. _____

<b>What is the history of your present illness?</b>

Please list the names of other practitioners you have seen for this problem: \_\_\_\_\_

**SYSTEMS REVIEW**

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last eye exam \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last chest x-ray \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last Tuberculosis test \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last bone densitometry \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last colonoscopy \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last prostate check \_\_\_\_/\_\_\_\_/\_\_\_\_

**Constitutional**

- Recent weight gain amount \_\_\_\_\_
- Recent weight loss amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

**Eyes**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

**Ears-Nose-Mouth-Throat**

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

**Cardiovascular**

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat

- High blood pressure
- High cholesterol
- Heart murmurs
- Heart failure
- Atherosclerotic heart disease
- Swollen legs or feet

**Respiratory**

- Shortness of breath
- Difficulty in breathing at night
- Cough
- Coughing of blood
- Wheezing (asthma)
- Pleurisy
- Tuberculosis

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Physician Initials: \_\_\_\_\_

**Gastrointestinal**

- Nausea
- Vomiting of blood or coffee ground material
- Esophagitis/GERDs
- Heartburn
- Hepatitis
- Increasing constipation
- Persistent diarrhea
- Blood in stools or black, tarry stools
- Pancreatitis or gallbladder
- Diverticulitis
- Ulcer
- Crohn's disease or ulcerative colitis

**Genitourinary**

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Pus in urine(cystitis)
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

**For Women Only**

Age when periods began \_\_\_\_\_  
 Periods regular?  Yes  No  
 How many days apart? \_\_\_\_\_  
 Date of last period \_\_\_/\_\_\_/\_\_\_  
 Date of last pap \_\_\_/\_\_\_/\_\_\_

Bleeding after menopause?

- Yes  No

Number of pregnancies \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

**Musculoskeletal**

- Morning stiffness  
Lasting how long?  
\_\_\_\_\_minutes \_\_\_\_\_hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
- Back and neck problems
- Fibromyalgia

**Integumentary (skin and/or breast)**

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold
- Psoriasis**

**Neurological System**

- Headaches
- Dizziness
- Fainting or loss of consciousness

- Muscle spasm
- Difficulty in walking or speaking
- Sensitivity or pain of hands and/or feet.neuropathy
- Memory loss
- Night sweats

**Endocrine**

- Diabetes
- Thyroid disease
- Excessive thirst

**Hematologic/Lymphatic**

- Swollen,tender glands
- Anemia
- Bleeding tendency
- Blood Transfusion - year
- Easy clotting of veins or arteries

**Allergic/Immunologic**

- Frequent sneezing
- Increased susceptibility to infection
- Frequent sinus problems
- Eczema

**Psychiatric**

- Depression
- Anxiety
- Other uncomfortable emotion
- Any clinical diagnosis

**MEDICATIONS**

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc. Use a separate page if necessary.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO, OR HAVE HAD A REACTION TO:

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Physician Initials: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you know or have you ever had: (check if "yes")

- Cancer     Heart Problems     Asthma
- Cataracts/Glaucoma     Diabetes
- Nervous breakdown     Stomach Ulcers
- Rheumatic Fever     Bad Headaches
- Neuropathy     Jaundice     Psoriasis
- Ulcerative Colitis/Crohn's Disease

- Kidney Disease     Pneumonia
  - HIV/AIDS     Anemia or other blood disease
  - Emphysema/Bronchitis     Tuberculosis
- Other significant illness: \_\_\_\_\_  
 \_\_\_\_\_

**PAST SURGICAL HISTORY**

TYPE	YEAR	REASON
1.		
2.		
3.		
4.		
5.		

Any serious injuries?     Yes     No

Describe: \_\_\_\_\_

**FAMILY HISTORY:**

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
<b>Father</b>				
<b>Mother</b>				

Number of Siblings \_\_\_\_\_    Number Living \_\_\_\_\_    Number Deceased \_\_\_\_\_

Number of Children \_\_\_\_\_    Number Living \_\_\_\_\_    Number Deceased \_\_\_\_\_

List ages of each child: \_\_\_\_\_

Health of children: \_\_\_\_\_

Do you know of any blood relative who has or had: (check and give relationship)

- Cancer \_\_\_\_\_     Heart disease \_\_\_\_\_     Rheumatoid arthritis \_\_\_\_\_     Tuberculosis \_\_\_\_\_
- Psoriasis \_\_\_\_\_     Lupus \_\_\_\_\_     Diabetes \_\_\_\_\_     Hepatitis \_\_\_\_\_
- Stroke \_\_\_\_\_     Bleeding tendency \_\_\_\_\_     Asthma \_\_\_\_\_     Spondylitis or colitis \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_

Do you drink caffeinated beverages? Cups/glasses per day? \_\_\_\_\_

Do you drink alcohol?     Yes     No.    Number per week \_\_\_\_\_.

Do you exercise regularly?     Yes     No

Type \_\_\_\_\_ Amount per week \_\_\_\_\_ Do you smoke?     Yes     No

Past – How long ago? \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Physician Initials: \_\_\_\_\_