STEVEN LEE FELDMAN, M.D., P.A.

ARTHRITIS AND RHEUMATIC DISEASES
7351 W. OAKLAND PARK BLVD.
SUITE 104
LAUDERHILL, FLORIDA 33319
PHONE (954) 741-5800 • FAX (954) 741-7828

NAME _____ SOC. SEC. # _____

ADDRESS _____ TELEPHONE NUMBER _____

DATE OF BIRTH _____ CITY, STATE, ZIP _____

REFERRED BY _____ HEALTH INSURANCE _____

EMail ADDRESS _____ ID NUMBER _____

MARITAL STATUS: MARRIED ( ) SINGLE ( ) DIVORCED ( ) SEPARATED ( ) WIDOW(ER) ( )

PRIMARY CARE PHYSICIAN _____

HIS/HER ADDRESS (CITY, STATE, ZIP) _____

IF YOU WERE NOT REFERRED BY YOUR PRIMARY CARE DOCTOR, DO YOU WANT A COPY OF DR. FELDMAN'S FINDINGS AND TREATMENT SENT TO HIM/HER? **YES** **NO**

WHAT IS THE MAIN PROBLEM YOU ARE HAVING THAT NEEDS TO BE EVALUATED?

_____

_____

_____

WHEN DID YOUR PROBLEM SEEM TO START? HOW MANY DAYS, WEEKS, MONTHS OR YEARS AGO?

_____

WHAT MEDICATIONS (include over the counter medications), IF ANY, HAVE YOU TAKEN TO TRY AND HELP THIS PROBLEM?

MEDICATION	**Mg STRENGTH**	**MEDICATION**	**Mg STRENGTH**

HAVE YOU CONSULTED WITH, OR BEEN TREATED BY ANY OTHER DOCTOR(S) FOR THIS PROBLEM?
(please check) **YES** _____ **NO** _____

NAME	**ADDRESS**	**CITY, STATE, ZIP**

PLEASE LIST BELOW YOUR CURRENT MEDICATIONS, THE DOSE (if known), HOW MANY TIMES A DAY YOU TAKE IT, AND THE CONDITION FOR WHICH IT WAS PRESCRIBED. PLEASE ALSO INCLUDE ANY OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS.

MEDICATION	**DOSE (# of mgs)**	**TIMES PER DAY**	**CONDITION**

NAME _____

PLEASE LIST BELOW ANY MEDICATIONS THAT YOU HAVE HAD A REACTION TO, ARE ALLERGIC TO, OR CANNOT TAKE. PLEASE ALSO GIVE THE REASON YOU CANNOT TAKE IT, OR THE TYPE OF REACTION YOU HAVE HAD.

MEDICATION	**REASON / REACTION**

PLEASE LIST BELOW ANY OPERATIONS THAT YOU HAVE HAD, AND IF YOU CAN REMEMBER, THE APPROXIMATE YEAR.

OPERATION	**YEAR**

PLEASE LIST BELOW HOSPITALIZATIONS (other than childbirth), THE APPROXIMATE YEAR, AND A BRIEF REASON FOR THE HOSPITALIZATION OR THE MEDICAL DIAGNOSIS.

NAME OF HOSPITAL	**YEAR**	**REASON / DIAGNOSIS**

PLEASE LIST BELOW ANY OTHER MEDICAL CONDITIONS YOU MAY CURRENTLY HAVE, OR HAVE HAD IN THE PAST, NOT MENTIONED IN THE SECTIONS ABOVE.

MEDICAL CONDITION OR DIAGNOSIS

HAVE YOU EVER BEEN TOLD YOU HAVE OR TREATED FOR THE SKIN DISEASE, PSORIASIS? _____

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING CONDITIONS? WHICH RELATIVE?

ARTHRITIS - type unknown _____ GOUT _____

DEFINITE RHEUMATOID ARTHRITIS _____ OSTEOPOROSIS _____

OSTEOARTHRITIS _____ CROHN'S DISEASE _____

PSORIASIS _____ ULCERATIVE COLITIS _____

LUPUS (SLE, systemic lupus) _____ ANKYLOSING SPONDYLITIS _____

SCLERODERMA _____ IRITIS (uveitis) _____

LYME DISEASE _____

JAME _____ pag

***Attention all patients: Some of the following questions are obviously for women only. Some are for men and women. Please read carefully.

VOMEN - PLEASE COMPLETE THE FOLLOWING: _____

.T WHAT AGE DID YOU START TO MENSTRUATE? _____

: YOU NO LONGER MENSTRUATE, AT WHAT AGE DID YOU STOP? _____

IOW MANY CUPS OF MILK DO YOU DRINK EACH DAY? _____

OW MANY CUPS OF YOGURT DO YOU EAT EACH DAY? _____

OW MANY SLICES, OUNCES, OR CUPS OR CHEESE DO YOU EAT EACH DAY? _____

REGNANCY HISTORY:

TOTAL NUMBER OF PREGNANCIES _____

TOTAL NUMBER OF LIVE BIRTHS _____

TOTAL NUMBER OF LIVING CHILDREN _____

)o you take calcium supplements? /_/yes /_/no If yes how many mg. a day____

[f post menopausal have you ever taken estrogen (female hormone)tablets or patche
/_/yes /_/ no

if yes during what years? or for how many years? _____

if no longer taking why was it discontinued? _____

lave you ever had any fractures or broken bones? /_/yes /_/no

if yes please list and age fracture ocurred _____

_____

)o you smoke? /_/yes /_/no

if yes for how many years and how much a day _____

if you don't currently smoke for how many years did you smoke & when did you stop? _____

)o you drink alcohol /_/yes /__/no if yes how many ounces or drinks/week _____

)o you drink coffee/tea/cola beverages /__/yes /__/ if yes how many a day _____

ave you ever had a bone density test?_____When?_____Results_____

EVIEWED BY:

TEVEN LEE FELDMAN, M.D. _____

ATE_____