Kathryn Naus Hester MD
Rheumatology

Medical History

Name: _____ Birthdate: _____/_____/_____
Last First Middle Int. Month Day Year

Phone: Home (___)_____ Cell: (___)_____ Work: (___)_____
Address: _____
Emergency Contact Person: _____ Phone: (___)_____ Relationship: _____
Referred here by: Dr. _____ Family/Friend _____ Other _____
Highest level of education: _____
Name of primary care physician: _____ Office phone: (___)_____
Please list the names of previous Rheumatologist(s): _____

Please list your health problems, surgeries, and/or hospitalizations:

Health Problems	Surgeries	Hospitalizations

Please list your current medications (if you need more space, please use back of page):

Medication	Dose	How Often	Medication	Dose	How Often
1.)			5.)		
2.)			6.)		
3.)			7.)		
4.)			8.)		

Family history of Arthritis? Yes _____ No _____ If yes, family member? _____
Do you smoke? Yes _____ No _____ If yes, how much per day and for how long?_____
Do you drink alcohol? Yes _____ No _____ If yes, how much and how often? _____
Do you have a history of substance abuse? Yes _____ No _____ If yes, what substance?_____
Do you have any medical allergies? Yes _____ No _____ If yes, please list and explain reaction: ____
_____
Do you take any natural or alternative therapies or over-the-counter preparations? Yes _____ No _____
If yes, please list: _____

_____ Date: _____
Patient Signature Date Completed

_____ Date: _____
Physician Signature Date Completed

Thank you for completing this form. We look forward to participating in your care.