"And the afflicted thou wilt save . . ."

Allergy & Rheumatology Associates, LLC

Michelle Spuza-Milord, M.D., F.A.C.R.
Ginige Swanthri De Silva M.D., F.A.C.R.

Name: ______________________________ **Date:** __________

Past Personal History: Do you or have you had: (mark any that apply)

- ☐ Thyroid Problems
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Pneumonia
- ☐ Liver Disease
- ☐ Connective Tissue disease
- ☐ Headaches
- ☐ Diabetes
- ☐ Heart disease
- ☐ Asthma
- ☐ Depression
- ☐ Kidney disease
- ☐ Immune disease
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Gastric disease
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Menta
- ☐ Lung disease

Past Surgical History: Please specify the procedure and the date.

Procedure: ________________ Date: __________ Procedure: ________________ Date: __________

Procedure: ________________ Date: __________ Procedure: ________________ Date: __________

Procedure: ________________ Date: __________ Procedure: ________________ Date: __________

Procedure: ________________ Date: __________ Procedure: ________________ Date: __________

Any previous fractures or serious injuries? ☐ YES ☐ NO Describe: ______________________________

Allergies to meds, food, environmental: ☐ YES ☐ NO Describe: ______________________________

Family History:

Father: Deceased ☐ YES ☐ NO Diseases: ______________________________

Mother: Deceased ☐ YES ☐ NO Diseases: ______________________________

Brothers/Sisters Diseases: ______________________________

Social History:

Married: ☐ YES ☐ NO Divorced: ☐ YES ☐ NO Separated: ☐ YES ☐ NO Widowed: ☐ YES ☐ NO

Smoking: ☐ YES ☐ NO If yes, how long: ________________ How much per day: ________________

Caffeine: ☐ YES ☐ NO If yes, how long: ________________ How much per day: ________________

Alcohol: ☐ YES ☐ NO If yes, how long: ________________ How much per day: ________________

Drugs: ☐ YES ☐ NO If yes, how long: ________________ How much per day/Type: ________________

On disability: ☐ YES ☐ NO Since when: ________________ Profession: ________________

Current Medications/Supplements List:

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________

Name: ________________ Strength: __________ How Often: __________