

RHEUMATOLOGY ASSOCIATES

Patient History Form

Date of first appointment: _____ / _____ / _____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: _____ / _____ / _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: F M
STREET APT#

_____ Telephone: Home (_____)
CITY STATE ZIP Work (_____)

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

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? Yes No If yes, Name: _____

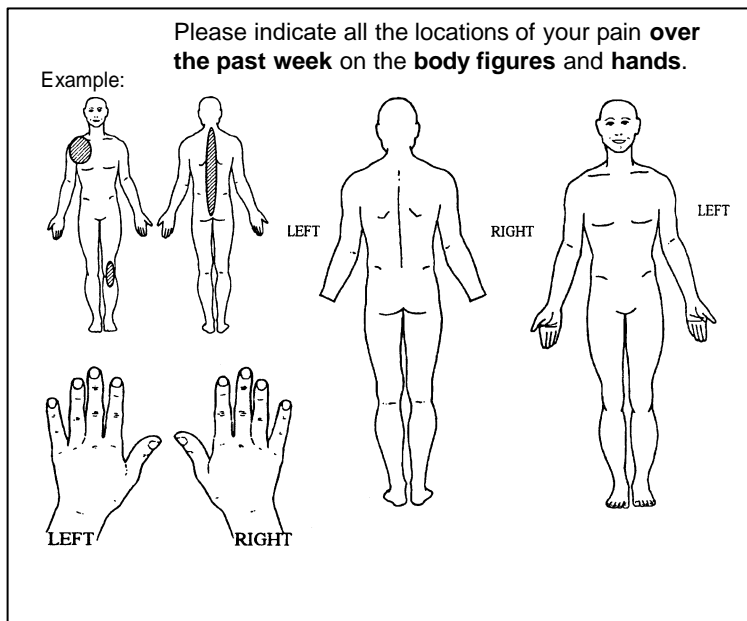
Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

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

Diagnosis given: _____



RHEUMATIC DISEASE (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Chronic fatigue syndrome

Other arthritis conditions: _____

REVIEW OF SYSTEMS

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

Musculoskeletal

- Morning stiffness

Lasting how long?

_____ Minutes _____ Hours

- Joint pain
 Joint swelling

List joints affected in the last 6 mos.

- Muscle weakness
 Muscle tenderness

Constitutional

- Generalized weakness
 Fatigue
 Fever or chills
 Night sweats
 Recent weight loss

amount _____

- Recent weight gain

amount _____

Eyes

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

Dermatology

- Thickness
 Tightness
 Rash
 Unexpected hair loss
 Sun sensitive (sun allergy)
 Redness
 Hives
 Nodules/bumps
 Nail pits

Psychiatric

- Excessive worries
 Anxiety
 Panic attacks
 Easily losing temper
 Depression
 Agitation
 Difficulty falling asleep
 Difficulty staying asleep

Gastrointestinal

- Nausea
 Vomiting
 Abdominal pain
 Heartburn
 Diarrhea
 Mucus in stools
 Unusual constipation
 Blood in stools
 Black/tarry stools

Genitourinary

- Difficulty urinating
 Blood in urine
 Pain or burning on urination
 Pus in urine
 Cloudy urine
 Sexual difficulties
 Genital rash/ulcers

For Women Only:

- Vaginal dryness
 Vaginal discharge

Date of last period? _____ / _____ / _____ / _____

Number of pregnancies? _____

Number of miscarriages? _____

For Men Only:

- Discharge from penis
 Prostate trouble

Respiratory

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

Neurological System

- Numbness or tingling in hands
 Numbness or tingling in feet
 Headaches
 Dizziness
 Fainting
 Muscle spasm
 Cramping in legs at night
 Memory loss

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Blood clot in artery, vein, or lung
 Bleeding tendency
 Enlarged lymph nodes
 Anemia
 Transfusion/when _____

Allergic/Immunologic

- Frequent sneezing
 Increased susceptibility to infection

Ears–Nose–Mouth–Throat

- Dryness of mouth
 Sinus pain
 Difficulty swallowing
 Sores in mouth
 Ringing in ears
 Loss of hearing
 Nosebleeds
 Loss of smell
 Bleeding gums
 Loss of taste
 Frequent sore throats
 Hoarseness

Cardiovascular

- Chest pain
 Difficulty in breathing at night
 Cramping in calves when walking
 Swollen legs or feet
 Color changes of hands in the cold
 Irregular heart beat
 Sudden changes in heart beat
 Heart murmurs

Please state the date of your last:

Bone Densitometry _____ / _____ / _____

Mammogram _____ / _____ / _____

Eye exam _____ / _____ / _____

Chest x-ray _____ / _____ / _____

Tuberculosis Test _____ / _____ / _____

Flu Vaccine _____ / _____ / _____

Pneumonia Vaccine _____ / _____ / _____

Tetanus Vaccine _____ / _____ / _____

Shingles Vaccine _____ / _____ / _____

Hepatitis B Vaccine _____ / _____ / _____

YOUR PAST MEDICAL HISTORY: Have **YOU** ever been diagnosed with any of the following diseases?

- | | | | | | |
|---|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer/Leukemia/Lymphoma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema/COPD/Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Sarcoidosis |

Other significant illness (not listed above): _____

Previous Operations/ Surgical History

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? No Yes Describe: _____

Any other serious injuries? No Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Year of Birth	Health	Age at Death	Cause
Father				
Mother				

Number of sisters _____ Number living _____ Number deceased _____ Number of brothers _____ Number living _____ Number deceased _____

Number of daughters _____ Number living _____ Number deceased _____ Number of sons _____ Number living _____ Number deceased _____

Health of children: _____

Do you know of any close blood relative (parent, sibling or child) who has or had: (check and give relationship)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Psoriasis _____ | |

SOCIAL HISTORY:

Marital Status: Never Married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses _____

How many people in household? _____ Relationship and age of each _____

Education (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Do you drink caffeinated beverage? No Yes Cups/glasses per day? _____

Do you smoke? No Yes Amount per day _____ Previous smoker? How long ago? _____

Do you drink alcohol? No Yes Number per week _____ Has anyone ever told you to cut down on your drinking? No Yes

Recreational drug use? No Yes If yes please list _____

Do you exercise regularly? No Yes Frequency _____ Please describe _____

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. **INCLUDE** Over the Counter Medications as well, such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

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"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, **how long** you were taking the medication, the **results** of taking the medication and list any **reactions** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrotec (diclofenac + misoprostil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin (including coated aspirin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Celebrex (celecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daypro (oxaprozin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dolobid (diflunisal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feldene (piroxicam)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indocin (indomethacin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lodine (etodolac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobic (meloxicam)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin (ibuprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naprosyn (naproxen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oruvail (ketoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voltaren (diclofenac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydrocodone (Vicodin, Lortab, Norco)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ultram/Ultracet (tramadol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Corticosteroids					
Decadron (dexamethasone)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medrol dose pack (methylprednisolone)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone injection (where) _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Arava (leflunomide)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Atabrine (quinacrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azulfidine (sulfasalazine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CellCept (mycophenolate mofetil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

DMARDS - Continued					
Cytoxan (cyclophosphamide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Imuran (azathioprine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Methotrexate (rheumatex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neoral or Sandimmune (Cyclosporine A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Plaquenil (hydroxychloroquine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Biologics					
Actemra (tocilizumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cimzia (certolizumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Enbrel (etanercept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Humira (adalimumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kineret (anakinra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Orencia (abatacept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Remicade (Infliximab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rituxan (rituximab):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Simponi (golimumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis Medications					
Actonel (risedronate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Boniva (ibandronate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Estrogen (Premarin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Evista (raloxifene)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Forteo (teriparatide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fosamax (alendronate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Miacalcin nasal spray (calcitonin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prolia (denosumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Reclast (zoledronic acid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Gout Medications					
Zyloprim (allopurinol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colcrys (colchicine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Benemid (probenecid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Uloric (febuxostat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Krystexxa (pegloticase)					
Others					
Hyalgan/Synvisc/Orthovisc/Euflexxa injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cymbalta (duloxetine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lyrica (pregabalin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neurontin (gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Savella (milnacipran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle Relaxers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sleep Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other anti-depressants:					

Have you participated in any clinical trials for new medications? Yes No If yes, list:

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ACTIVITIES OF DAILY LIVING

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

Because of health problems do you have difficulty:
(Please check the appropriate response for each question.)

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
1. Dress yourself, including tying shoelaces and doing buttons?	___0	___1	___2	___3
2. Get in and out of bed?	___0	___1	___2	___3
3. Lift a full cup or glass to your mouth?	___0	___1	___2	___3
4. Walk outdoors on flat ground?	___0	___1	___2	___3
5. Wash and dry your entire body?	___0	___1	___2	___3
6. Bend down to pick up clothing from the floor?	___0	___1	___2	___3
7. Turn regular faucets on and off?	___0	___1	___2	___3
8. Get in and out of a car, bus, train, or airplane?	___0	___1	___2	___3
9. Reaching behind your head?	___0	___1	___2	___3
10. Reaching behind your back?	___0	___1	___2	___3
11. Going to sleep?	___0	___1	___2	___3
12. Staying asleep due to pain?	___0	___1	___2	___3
13. Obtaining restful sleep?	___0	___1	___2	___3
14. Climbing stairs?	___0	___1	___2	___3
15. Descending stairs?	___0	___1	___2	___3
16. Working?	___0	___1	___2	___3
17. Getting along with family members?	___0	___1	___2	___3
18. Engaging in leisure time activities?	___0	___1	___2	___3

What is the hardest thing for you to do? _____

Do you use a cane, crutches, walker, or a wheelchair? (check all that apply)

Are you receiving disability?..... Yes No

Are you applying for disability?.....Yes No

Do you have a medically related lawsuit pending?.....Yes No

Considering that all of the ways your arthritis has affected you over the past week, please place a vertical mark on the line below to show how you are feeling:

VERY GOOD 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 — VERY POOR

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle on line below.

NO PROBLEM 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 MAJOR PROBLEM

How much pain have you had because of your condition OVER THE PAST WEEK? Please circle on the line below.

NONE 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 AS BAD AS IT COULD BE