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)

_____

_____

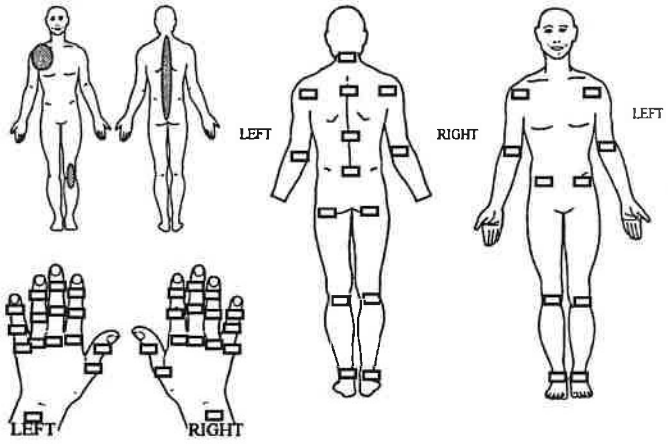
Please list the names of other practitioners you have seen for this problem:

_____

Diagnosis given: _____

Please indicate all the locations of your pain **over the past week** on the **body figures** and **hands.**

Example:



RHEUMATIC DISEASE (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
	Fibromyalgia			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?

❑ Cancer/Leukemia/Lymphoma	❑ Heart Disease	❑ Diabetes	❑ High blood pressure	❑ High Cholesterol	❑ Stroke
❑ Emphysema/COPD/Asthma	❑ Kidney disease	❑ Thyroid disease	❑ Jaundice/Hepatitis	❑ Tuberculosis	❑ Pneumonia
❑ HIV/ AIDS	❑ Headaches/Migraines	❑ Depression	❑ Nervous Breakdown	❑ Glaucoma	❑ Anemia
❑ Rheumatic Fever	❑ Epilepsy	❑ Psoriasis	❑ Colitis	❑ Iritis/Uveitis	❑ 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)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever_____	❑ Tuberculosis __
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy_____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism_____	❑ 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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

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? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		☐	☐	☐	
Arthrotec (diclofenac + misoprostil)		☐	☐	☐	
Aspirin (including coated aspirin)		☐	☐	☐	
Celebrex (celecoxib)		☐	☐	☐	
Daypro (oxaprozin)		☐	☐	☐	
Dolobid (diflunisal)		☐	☐	☐	
Feldene (piroxicam)		☐	☐	☐	
Indocin (indomethacin)		☐	☐	☐	
Lodine (etodolac)		☐	☐	☐	
Mobic (meloxicam)		☐	☐	☐	
Motrin (ibupoprofen)		☐	☐	☐	
Naprosyn (naproxen)		☐	☐	☐	
Oruvail (ketoprofen)		☐	☐	☐	
Voltaren (diclofenac)		☐	☐	☐	
Other_____		☐	☐	☐	
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Tylenol 3)		☐	☐	☐	
Hydrocodone (Vicodin, Lortab, Norco)		☐	☐	☐	
Ultram/Ultracet (tramadol)		☐	☐	☐	
Corticosteroids					
Decadron (dexamethasone)		☐	☐	☐	
Medrol dose pack (methylprednisolone)		☐	☐	☐	
Prednisone		☐	☐	☐	
Cortisone injection (where)_____		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Arava (leflunomide)		☐	☐	☐	
Atabrine (quinacrine)		☐	☐	☐	
Azulfidine (sulfasalazine)		☐	☐	☐	
CellCept (mycophenolate mofetil)		☐	☐	☐	

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

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

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 c☐e, cr☐es, w☐er, or a wh☐chair? (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 ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ 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 ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ MAJOR PROBLEM

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

NONE ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ AS BAD AS IT COULD BE