Rheumatology & Arthritis Patient History

Date of first appointment: _____ Time of appointment: _____

Name: _____ Date of Birth: _____ Birthplace: _____

Telephone (home): _____ Work#: _____

Marital Status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse / significant other: Alive/age: _____ Deceased / age: _____ Major illnesses: _____

Referred here by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other health professional

Name of person who referred you: _____

Name of physician who provides your primary care: _____ Phone: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximately): _____ Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery & injections): _____

Do you smoke? ☐ Yes ☐ No ☐ Past If past how long ago? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks per week? _____

Surgeries: _____

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

Past Medical History (do you now have or have you ever had?)

☐ Cancer	☐ Heart problems	☐ Asthma	☐ Emphysema / COPD
☐ Goiter	☐ Leukemia	☐ Stroke	☐ Glaucoma
☐ Cataracts	☐ Diabetes	☐ Epilepsy	☐ Tuberculosis
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever	☐ Anemia
☐ Bad headaches	☐ Jaundice	☐ Colitis	☐ HIV / AIDS
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis	☐ High blood pressure

Other significant illnesses: _____

Natural or alternative therapies (include chiropractic, magnets, massage, over the counter preparations)

Family history:

	If living: Age	Health	If deceased: Age at death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Do you know of any blood relative who has or had (check box and give relationship)

☐ Cancer	_____	☐ Heart Disease	_____	☐ Rheumatic fever	_____
☐ Leukemia	_____	☐ High blood pressure	_____	☐ Epilepsy	_____
☐ Stroke	_____	☐ Bleeding tendency	_____	☐ Asthma	_____
☐ Colitis	_____	☐ Alcoholism	_____	☐ Psoriasis	_____
☐ Rheumatoid Arthritis	_____	PSA (Psoriatic Arthritis)	_____	☐ Gout	_____
☐ Juvenile RA	_____	AS (Ankylosing Spondylitis)	_____	☐ Lupus	_____
☐ Tuberculosis	_____	Diabetes	_____	☐ Goiter	_____

Systems Review

Date of last eye exam: _____

Date of tuberculosis test: _____ Date of last bone density scan: _____

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

Constitutional

- Recent weight gain ☐ Yes ☐ No
- Amount: _____
- Recent weight loss ☐ Yes ☐ No
- Amount: _____
- Fatigue ☐ Yes ☐ No
- Weakness ☐ Yes ☐ No
- Fever ☐ Yes ☐ No

Eyes

- Loss of vision ☐ Yes ☐ No
- Double or blurred vision ☐ Yes ☐ No
- Dryness ☐ Yes ☐ No

Ears-Nose-Mouth-Throat

- Ringing in ears ☐ Yes ☐ No
- Loss of hearing ☐ Yes ☐ No
- Nosebleeds ☐ Yes ☐ No
- Loss of smell ☐ Yes ☐ No
- Dryness in nose ☐ Yes ☐ No
- Sore tongue ☐ Yes ☐ No
- Bleeding gums ☐ Yes ☐ No
- Sores in mouth ☐ Yes ☐ No
- Loss of taste ☐ Yes ☐ No
- Dryness of mouth ☐ Yes ☐ No
- Frequent sore throats ☐ Yes ☐ No
- Hoarseness ☐ Yes ☐ No
- Difficulty swallowing ☐ Yes ☐ No

Gastrointestinal

- Nausea ☐ Yes ☐ No
- Vomiting blood or coffee ground material ☐ Yes ☐ No
- Stomach pain relieved by food or drink ☐ Yes ☐ No
- Jaundice ☐ Yes ☐ No
- Increasing constipation ☐ Yes ☐ No
- Persistent diarrhea ☐ Yes ☐ No
- Blood in stools ☐ Yes ☐ No
- Black stools ☐ Yes ☐ No
- Heartburn ☐ Yes ☐ No

Genitourinary

- Difficult urination ☐ Yes ☐ No
- Pain or burning on urination ☐ Yes ☐ No
- Blood in urine ☐ Yes ☐ No
- Cloudy/smoky urine ☐ Yes ☐ No
- Pus in urine ☐ Yes ☐ No
- Discharge from penis/vagina ☐ Yes ☐ No
- Getting up at night to pass urine ☐ Yes ☐ No
- Vaginal Dryness ☐ Yes ☐ No
- Rash/ulcers ☐ Yes ☐ No
- Sexual difficulties ☐ Yes ☐ No
- Prostate troubles ☐ Yes ☐ No

Musculoskeletal

- Morning stiffness ☐ Yes ☐ No
- Last how long: ____min ____hrs
- Joint pain ☐ Yes ☐ No
- Muscle weakness ☐ Yes ☐ No
- Muscle tenderness ☐ Yes ☐ No
- Joint swelling ☐ Yes ☐ No

Integumentary (skin/breast)

- Easy bruising ☐ Yes ☐ No
- Redness ☐ Yes ☐ No
- Rash ☐ Yes ☐ No
- Hives ☐ Yes ☐ No
- Tightness ☐ Yes ☐ No
- Nodules/bumps ☐ Yes ☐ No
- Color changes of hand/feet in cold ☐ Yes ☐ No
- Hair loss ☐ Yes ☐ No

Neurological System

- Headaches ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Fainting ☐ Yes ☐ No
- Muscle spasm ☐ Yes ☐ No
- Sensitivity/pain of hands/feet ☐ Yes ☐ No
- Memory loss ☐ Yes ☐ No

Psychiatric

- Excessive worries ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Easily losing temper ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Agitation ☐ Yes ☐ No
- Difficulty falling asleep ☐ Yes ☐ No
- Difficulty staying asleep ☐ Yes ☐ No

Cardiovascular

Irregular heart beat	☐ Yes	☐ No
Sudden changes in heartbeat	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No

Respiratory

Shortness of breath	☐ Yes	☐ No
Difficulty breathing at night	☐ Yes	☐ No
Swollen legs/feet	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing of blood	☐ Yes	☐ No
Wheezing (asthma)	☐ Yes	☐ No

Allergic/Immunologic

Frequent sneezing	☐ Yes	☐ No
Increased susceptibility to infection	☐ Yes	☐ No

Endocrine

Excessive thirst	☐ Yes	☐ No

Hematologic / Lympathic

Swollen glands	☐ Yes	☐ No
Tender glands	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No
Transfusion	☐ Yes	☐ No

when: _____

Prior arthritis medications tried:

☐ Plaquenil	☐ Humira	☐ Xeljanz	☐ Cosentyx
☐ Gold	☐ Remicade	☐ Otezla	☐ Stelara
☐ Sulfasalazine	☐ Actemra	☐ Orencia	
☐ Methotrexate	☐ Simponi	☐ Kevzara	
☐ Prednisone	☐ Cimzia	☐ Azathioprine	
☐ Enbrel	☐ Rituxan	☐ Cellcept	

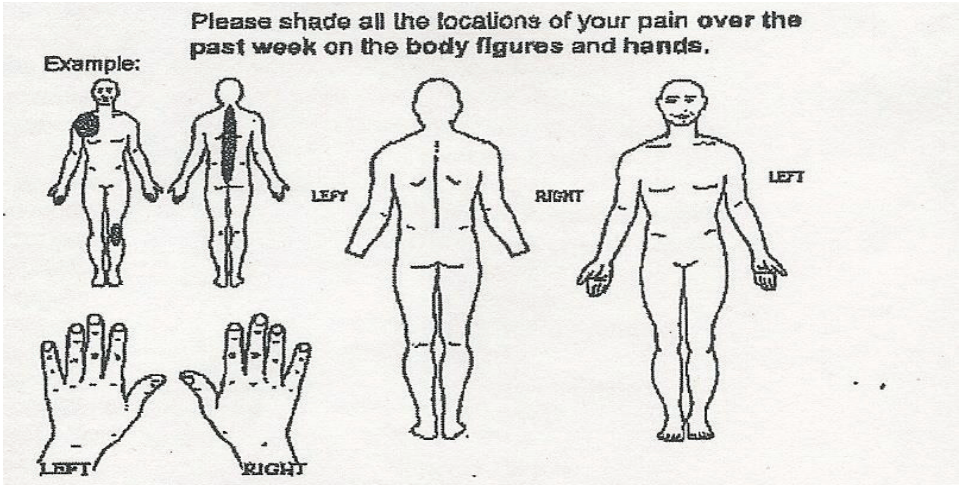
☐ Other: _____

Social history

Occupation? _____

Prior pregnancies / miscarriages? _____

Exercise? _____



Patient's Signature _____ Date/Time _____

Witness Signature _____ Date/Time _____

Signature of Authorized Person _____ Date/Time _____

Relationship to Patient _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)