# RHEUMATOLOGY ASSOCIATES

## Patient History Form

Date of first appointment:____/____/____ Time of appointment:_____ Birthplace:_____
MONTH DA Y 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: _____

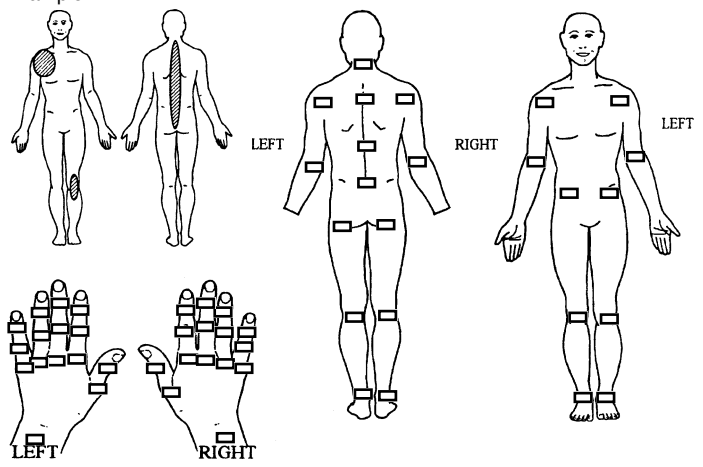
Date symptoms began (approximate): _____

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**.




**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 | |
| 12 | 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, cru☐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

**Submit**

If you are unable to click the Submit button above please save the document and email it to MedRec@DFWRA.com