Advanced Rheumatology
Autoimmunity & Arthritis Institute

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Date of birth: __/_____/_____
Last First M. I.

Age:_____ Sex: ☐ F ☐ M

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Name of previous Rheumatologist if any:_____

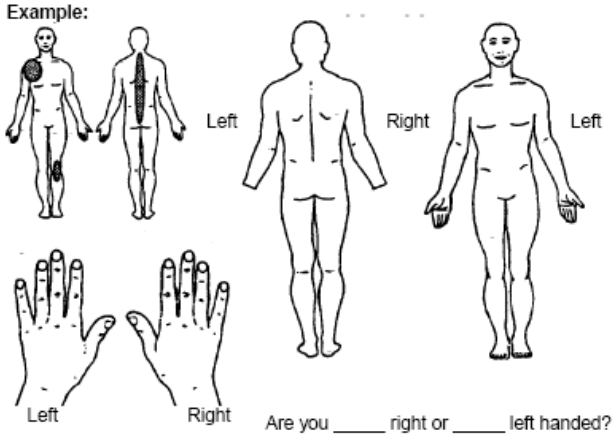
Describe briefly your present symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any and where/when were you diagnosed?

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

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

List any other medical problem(s) you see a Doctor(s)/Practitioner(s) for presently or in the past.

Please list the names of other Doctors/practitioners you see for any/other medical condition(s):

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

List the Medications you have been on in the past your rheumatologic condition; please includes start and stop dates.

Where do you get your labs done?_____

Please list any new medications or recent medication changes including dosages.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative		Name/relationship
Arthritis (type unknown)	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Rheumatoid arthritis	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Lupus or "SLE"	☐	☐	☐	_____
Ankylosing spondylitis	☐	☐	☐	_____
Childhood arthritis	☐	☐	☐	_____
Sjogren's syndrome	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Psoriasis/psoriatic arthritis	☐	☐	☐	_____

PAST MEDICAL HISTORY

Do you have now or have you ever had: (check if "yes")

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Hypothyroidism
☐ Goiter
☐ Cancer (type) _____
☐ Leukemia
☐ Psoriasis
☐ Angina
☐ Heart problems
☐ Heart murmur
☐ Pneumonia
☐ Pulmonary embolism
☐ Asthma
☐ Emphysema
☐ Stroke
☐ Epilepsy (seizures)
☐ Cataracts
☐ Kidney disease
☐ Kidney stones
☐ Crohn's disease
☐ Colitis
☐ Anemia
☐ Jaundice
☐ Hepatitis
☐ Stomach or peptic ulcer
☐ Rheumatic fever
☐ Tuberculosis
☐ HIV/AIDS

Other significant illnesses (please list): _____

_____

Previous Operations

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

Any previous fractures? ☐ No ☐ Yes Describe _____

Any other serious injuries? ☐ No ☐ Yes Describe _____

Do you smoke? ☐ Yes ☐ No ☐ In the past - How long ago? _____

Do you drink alcohol? ☐ No ☐ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ No ☐ Yes If yes, please list: _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐

MEDICATIONS

Drug allergies: □ No □ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? □ High school □ Some college courses □ College graduate □ Advanced degree

What is your current or past occupation? _____

Are you currently working? : □ Yes □ No If yes, hours/week _____ If not, are you □ retired □ disabled □ sick leave?

Do you receive disability or SSI? □ Yes □ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: □ Never done □ Negative □ Positive Date test performed: _____

GENERAL
□ Recent weight gain; how much_____
□ Recent weight loss: how much_____
□ Fatigue
□ Flushing
□ Weakness
□ Fever
□ Easy bruising
□ Night sweats
□ Heat or cold intolerance

MUSCLE/JOINTS/BONES

□ Morning stiffness
Lasting how long ____ Minutes
____ Hours
□ Joint pain

□ Muscle weakness
□ Joint swelling
□Joint redness
List joints affected in the last 6 months

_____
_____
_____
_____

EARS
□ Ringing in ears
□ Loss of hearing
□Floppy ear

EYES
□ Pain
□ Redness
□ Loss of vision
□ Double or blurred vision
□ Dryness
□ Feels like something in eye

MOUTH
□ Sore tongue/throat
□ Bleeding gums
□ Sores in mouth/nose
□Loss of taste
□ Dryness
□ Recent increase in tooth cavities
□Voice change (Hoarsness)

NOSE
□ Nosebleeds
□Sinusitis(recurrent)
□ Loss of smell/deformity

THROAT
□ Frequent sore throats
□ Hoarseness
□ Difficulty in swallowing(solid/liquid)
□ Pain with swallowing
□ Pain in jaw while chewing

NECK
□Swollen glands
□ Tender glands

HEART AND LUNGS
□ Pain in chest
□ Irregular heart beat

□ Sudden changes in heart beat

□ Shortness of breath
□ Difficulty in breathing at night
□ Swollen legs or feet
□ Cough
□ Coughing of blood
□ Wheezing

STOMACH AND INTESTINES

□ Nausea
□ Heartburn
□ Stomach pain relieved by food
□Vomiting of blood/"coffee grounds"
□ Yellow eyes/jaundice
□ Increasing constipation
□ Persistent diarrhea
□ Blood in stools
□ Black stools

KIDNEY/URINE/BLADDER
□ Difficult urination
□ Pain or burning on urination
□ Blood in urine
□ Cloudy, "smoky",foamy urine
□ Pus in urine
□ Discharge from penis/vagina
□ Frequent urination
□ Getting up at night to pass urine
□Vaginal dryness
□ Rash/ulcers

□ Sexual difficulties
□ Prostate trouble

BLOOD
□ Anemia
□ Bleeding tendency
□Low blood count
□Blood transfusion(s)

SKIN

□Nail problems
□ Redness
□ Rash
□ Hives
□Skin itching /scaling
□ Sun sensitive
□ Skin tightness
□ Nodules/bumps/swollen lymphnodes
□ Hair loss
□ Hair thinning
□ Color changes of
hands or feet in the
cold (Raynaud's)

NERVOUS SYSTEM
□ Headaches
□ Dizziness/vertigo
□ Fainting or loss of consciousness
□ Numbness or tingling in hands/feet
□ Poor grip
□ Memory loss
□ Muscle weakness

PSYCHIATRIC
□ Depression
□ Excessive worries
□ Difficulty falling asleep
□ Difficulty staying asleep

For women only:
Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
□ No □ Yes If yes, at what age: _____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? □ Yes □ No

How many days apart? _____