Dallas Diagnostic Association
Rheumatology
4716 Alliance Blvd., Ste 775
Plano, TX 75093 (469) 800-6037

Patient History Form

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

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

Address: _____ (STREET APT#) Age: _____ Sex: ❑ F ❑ M

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

_____

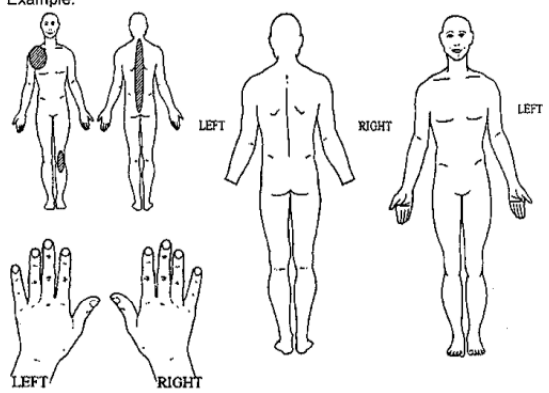
_____

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

_____

Diagnosis given:_____

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



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

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:					

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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____/____/____

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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 _____

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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)		❑	❑	❑	

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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:

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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, as walker or a wheelchair? (circle one)

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

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