Patient History Form

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

Name: _____Birthdate: ____/____/_____
LAST FIRST MIDDLE MAIDEN

Address: _____ Age: _____ Sex: □ F □ M
STREET APT#

_____ Telephone: Home (___)_____
CITY STATE ZIP Work (___)_____

Referred her by: (check one) □ Self □ Family □ Friend □ Doctor □ Other Health Professional

Name of person making referral: _____
Name of physician providing your primary medical care: _____
Do you have an orthopedic surgeon? □ Yes □No If yes, Name: _____
Describe briefly your present symptoms:

_____
_____
_____
_____
_____
_____
_____
_____

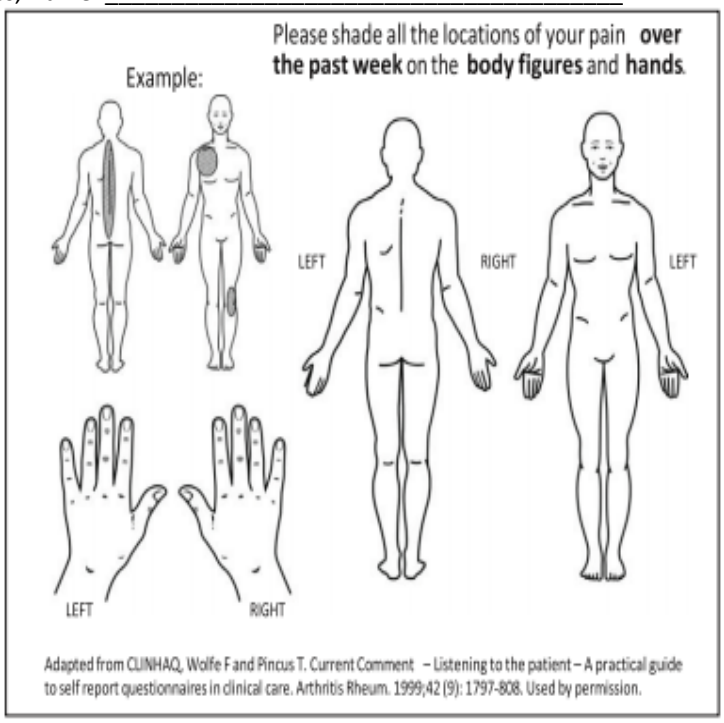
Date symptoms began (approximate): _____
Previous treatment for this problem (Include physical therapy, surgery and injections; medications to be listed later)

_____
_____
_____

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

_____

Diagnosis given: _____
_____



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	

Patient Name: _____ Date: _____ Physician initials: _____

REVIEW OF SYMPTOMS

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 6mths
_____
_____
_____
_____
_____
□ 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 moth 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 last 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 ___/___/___

Patient's Name_____ Date _____ Physician initials _____

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 of 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:_____

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 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 type _____

Do you exercise regularly? □ No □ Yes Frequency _____ Please describer _____

Patient's Name _____ Date _____ Physician initials _____

MEDICATION

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, laxative, 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
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□
			□	□	□

Review of system – Rheumatology

Currently or in the past have you had any of the following? Circle yes or no please		
Dry eyes/dry mouth	Yes	No
Fingers changing color in the cold	Yes	No
Eye redness	Yes	No
Blood Clots (legs, lungs)	Yes	No
Fluid around the heart	Yes	No
Fluid around the lungs	Yes	No
Rash	Yes	No
Photosensitivity	Yes	No
Joint swelling	Yes	No
Oral ulcers	Yes	No
Genital ulcers	Yes	No
Hair loss/bald spots	Yes	No
Fever (in the past 6 weeks)	Yes	No
Low blood counts	Yes	No
Seizure	Yes	No
Difficulty thinking clearly	Yes	No
Diarrhea/blood in stool	Yes	No
If female; history of miscarriages/abortion	Yes	No

Patient Name: _____ Date: _____ Physician Initials: _____