

Patient History Form

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

Name: Birthdate: / /
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: Age Sex: F M
STREET APT#
 Telephone: Home: ()
CITY STATE ZIP Work: ()

MARITAL STATUS: Never Married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age Deceased/Age Major Illnesses:

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 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:

Describe briefly your present symptoms:

Date symptoms began (approximate):

Diagnosis:

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:

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

Example:

LEFT RIGHT LEFT

LEFT RIGHT

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.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions:

Patient's Name: Date: Physician Initials:

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- Recent weight gain amount _____
- Recent weight loss amount _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

Ears-Nose-Mouth-Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Cardiovascular

- Chest Pain
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

Respiratory

- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

Gastrointestinal

- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? Yes No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? Yes No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
 Cups/glasses per day? _____
 Do you smoke? Yes No Past – How long ago? _____
 Do you drink alcohol? Yes No Number per week _____
 Has anyone ever told you to cut down on your drinking?
 Yes No

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

Do you exercise regularly? Yes No
 Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

PREVIOUS SURGERIES

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	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of Children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children _____

Do you know any blood relative 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 _____

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICAL HISTORY

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

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

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

MEDICATIONS

Drug allergies: No Yes If yes, please list: _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include 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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Circle any you have taken in the past</i>					
Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Certolizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Golimumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tocilizumab		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: <i>Helped?</i>			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyaluronan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please list supplements:

Have you participated in any clinical trials for new medications? Yes No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

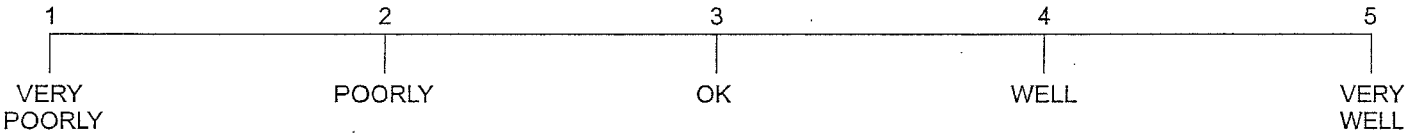
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? Yes No If yes, how many?

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; Most of the time, I function...



Because of health problems, do you have difficulty: (Please check the appropriate response for each question.)

Table with 3 columns: Activity, Usually, Sometimes, No. Rows include: Using your hands to grasp small objects?, Walking?, Climbing stairs?, Descending stairs?, Sitting down?, Getting up from chair?, Touching your feet while seated?, Reaching behind your back?, Reaching behind your head?, Dressing yourself?, Going to sleep?, Staying asleep due to pain?, Obtaining restful sleep?, Bathing?, Eating?, Working?, Getting along with family members?, In your sexual relationship?, Engaging in leisure time activities?, With morning stiffness, Do you use a cane, crutches, walker or wheelchair? (circle one)

What is the hardest thing for you to do? _____

- Are you receiving disability? Yes No
Are you applying for disability? Yes No
Do you have a medically related lawsuit pending? Yes No

Patient's Name: _____ Date: _____ Physician Initials: _____