



Rheumatology Patient History Form

Name: _____ Birthdate: ____/____/____ Age: _____
LAST FIRST MIDDLE INITIAL MONTH DAY YEAR

Address: _____

Home Phone: _____ Work Phone: _____ Sex: F M

Marital Status: Single (Never Married) Married Divorced Separated Widowed

Education (circle highest level attended):

Grade School Junior High High School College (circle year) 1 2 3 4 Graduate School

Occupation: _____ Number of hours worked/average per week _____

Date of first appointment: _____

Reason for today's visit: _____

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): _____

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:

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 ____/____/____

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

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

Other significant illness (please list): _____

Patient Name: _____

DOB: _____

ALLERGIES: List medications that you are allergic/intolerant to:

Current Medications: List medicines, birth control pills, vitamins you take with or without prescription: Please include name, dosage, and frequency.

HOSPITALIZATIONS/SURGERIES: List illnesses or operations and approximate year.
EXCLUDE NORMAL PREGNANCIES.

Any other serious injuries? No Yes Describe: _____

FAMILY HISTORY: Do you know of any blood relative who has or had: (check and give relationship)

<input type="checkbox"/> Cancer	
<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Heart disease	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Rheumatic fever	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Colitis	
<input type="checkbox"/> Bleeding tendency	
<input type="checkbox"/> Alcoholism	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Goiter	
<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	
<input type="checkbox"/> Other arthritis conditions:	
<input type="checkbox"/> Other medical conditions:	

SOCIAL HISTORY

Do you smoke? Yes No Past – How long ago? _____ Number per day/week/month: _____

Do you drink alcohol? Yes No Number per day/week/month: _____

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: _____

Patient Name: _____

DOB: _____

Do you live in a house or an apartment? _____

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

Number of people in household? _____

Relationship and age of each? _____

Who does most of the housework? _____

Do you use (circle one) Cane Crutches Walker Wheelchair? If yes, how often _____

How much PAIN are you having today? Circle below:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Most severe Pain

How much fatigue (tiredness) are you having? Circle below:

No Fatigue 0 1 2 3 4 5 6 7 8 9 10 Fatigue as bad as it could be

Circle which describes how you feel lately?

Very Poorly Poorly Okay Well Very well

What is the most difficult activity for you to do? _____

Please Circle:

Are you receiving disability? Yes No

Are you applying for disability? Yes No

Do you have a medical related lawsuit pending? Yes No

BECAUSE OF JOINT PAIN DO YOU HAVE DIFFICULTY:

OFTEN	OCCASIONALLY	NEVER	
			Using your hands to grasp small objects?
			Walking?
			Climbing Stairs?
			Descending Stairs?
			Sitting down?
			Getting up from chair?
			Reaching overhead?
			Reaching behind?
			Dressing yourself?
			Sleep problems (insomnia)?
			Bending
			Bathing
			Eating?
			Working?
			In your sexual relationship?
			Engaging in leisure activities?
			With morning stiffness?

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____