Midwest Orthopaedic Institute

Rheumatology Patient History Form

Name: _____ Date: _____

Please fill out and/or circle your answer. Please skip what does not apply to you. Thank you.

1. Do you have pain? __ No __ Yes.
   If yes, please circle where you have pain:

   Right side: Fingers Wrist Elbow Shoulder Hip Knee Ankle Toes

   Left Side: Fingers Wrist Elbow Shoulder Hip Knee Ankle Toes

   Neck Mid back Low back Arm muscles Leg muscles Others: _____

2. What is the nature of the pain?
   Aching Burning Stabbing Cramping Electric shock Pins & Needles Pulling

3. When did your symptoms start? ___ Days ___Weeks ____ Months ____ Years

4. Did your symptoms start? All of a sudden Gradually

5. Do your symptoms? ____Come and go ___Steady all the time

6. When do you have the least symptoms? ___Morning ___Afternoon ___ Evening ___Night

7. When do you have the most symptoms? ___Morning ___Afternoon ___ Evening ___Night

8. What makes your pain better?
   Rest Activity Medication Exercise Heat Ice Others_____

9. What makes your pain worse?
   Rest Activity Medication Exercise Heat Ice Others_____

10. Do your symptoms disturb your sleep? ___Yes __ No
11. Do you get enough sleep at night? ___Yes __ No
12. Do you wake up feeling rested? ___Yes __ No
13. Did you have any of the following prior to the onset of your symptoms?
    ___Viral syndrome __Stomach virus __Stressful situation __Car accident __Other injury
    Others:_____

14. Do you have joint swelling? ___No ___Yes

15. Do you have morning stiffness? ___No ___Yes
    How long does the morning stiffness last? Minutes: 5 10 15 30 45
    Hour: 1 2 3 4 5
    All day
16. Do you have muscle weakness? ___No ___Yes

Name:_____

ALLERGIES: Are you allergic to any medication? ___No ___Yes

If yes, to what? ___Penicillin, what happened?_____

___Sulfa, what happened?_____

___Aspirin, what happened?_____

___Others, what happened?_____

Please check any **Arthritis Medications** you have used **in the PAST**:

	Advil		Motrin		Ibuprofen		Actmera		Rituxan
	Celebrex		Cimzia		Cyclosporine		Orencia		Prednisone
	Indocin		Allopurinol		Colchicine		Probencid		Imuran
	Methotrexate		Plaquenil		Arava		Azulfidine		Estrogen
	Minocycline		Simponi		Cytoxan		Cellcept		
	Enbrel		Remicade		Kineret		Humira		
	Miacalcin		Fosamax		Actonel		Evista		

PAST MEDICAL HISTORY:

Do **you** now have, or have you ever had (check if Yes):

___Diabetes	___Cancer	___Colitis
___High Blood Pressure	___Kidney Disease	___Heart Problems
___Psoriasis	___Stomach Ulcers	___Depression
___Rheumatic Fever	___Under-active thyroid	___Tuberculosis

Other significant illnesses:_____

Previous Operations:_____

Any previous fractures? ___No ___Yes_____

Date of last Bone Densitometry (DEXA):_____

SOCIAL HISTORY:

Marital Status: ___Never Married ___Married ___Separated ___Divorced ___Widowed

Employment: ___F/T ___P/T ___Student ___Homemaker ___Disabled ___Unemployed

Occupation:_____

Do you **smoke**? ___Never

___Yes Packs/Day:___ # of Years:___

___Past How long ago did you quit?_____

Do you drink **Alcohol**? ___No ___Yes Number of drinks per week:_____

Do you **exercise** regularly? ___No ___Yes Amount per week:_____

FAMILY HISTORY:

Do you know of **any blood relative** that currently has or has previously had:

___Arthritis (Unknown Type)	___Scleroderma	___Rheumatic Fever
___Lupus or 'SLE'	___Gout	___Psoriasis
___Osteoarthritis	___Ankylosing Spondylitis	___Colitis
___Rheumatoid Arthritis	___Osteoporosis	

___Other significant illnesses:_____

Name:_____

Please briefly describe your symptoms. (In other words, what brings you to us today?)

_____

_____

_____

REVIEW OF SYMPTOMS:

Please check any items that have significantly affected you.

Skin:
___Rash
___Easy bruising
___Sun sensitivity
___Tightness
___Nodules/bumps
___Hair loss
___Color changes of hands or feet in the cold

Eyes:
___Redness/inflammation
___Loss of vision
___Dry eyes

Ear:
___Loss of hearing

Nose:
___Sores on the nose

Mouth/Throat:
___Dry mouth
___Sores in mouth
___Difficulty chewing
___Difficulty swallowing

GEN:
___Recent weight gain
___Recent weight loss
___Fatigue
___Fever

Heart:
___Chest pain
___Palpitations
___Heart murmurs

Respiratory:
___Cough
___Sputum
___Shortness of breath

Gastrointestinal:
___Nausea
___Vomiting
___Heartburn
___Abdominal pain

Genitourinary:
___Difficulty urinating
___Discharge from penis/vagina

Endocrine:
___Heat intolerance
___Cold intolerance

Hematologic:
___Anemia
___Blood clots

Psychiatric:
___Excessive worries
___Anxiety
___Depression
___Agitation

Neuro:
___Headaches
___Muscle spasms
___Memory loss

For Women Only:
___Vaginal dryness
Periods regular?
___Yes ___No
Postmenopausal?
___Yes ___No
Number of miscarriages:
_____

PRESENT MEDICATIONS:

Please list any medications you are taking, **INCLUDING** over the counter items such as aspirin, vitamins, laxatives, calcium, herbal supplements, etc. Please include dosage and frequency.

1		6	
2		7	
3		8	
4		9	
5		10	