**Patient History Form**

**North Houston Rheumatology Associates**

**MARITAL STATUS**:

o Married

Spouse/Significant Other: o Alive/Age \_\_ o Deceased/Age Major Illnesses \_

**EDUCATION** (circle highest level attended):

College

Grade School 7 8 9 10 11 12

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of hours worked/average per week \_\_\_\_\_\_\_

Graduate School:

Name of person making referral:

The name of the physician providing your primary medical care:

Do you have an orthopedic surgeon? o Yes o No If yes, Name:

Describe briefly your present symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred here by: (check one)

o Self

o Family

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:

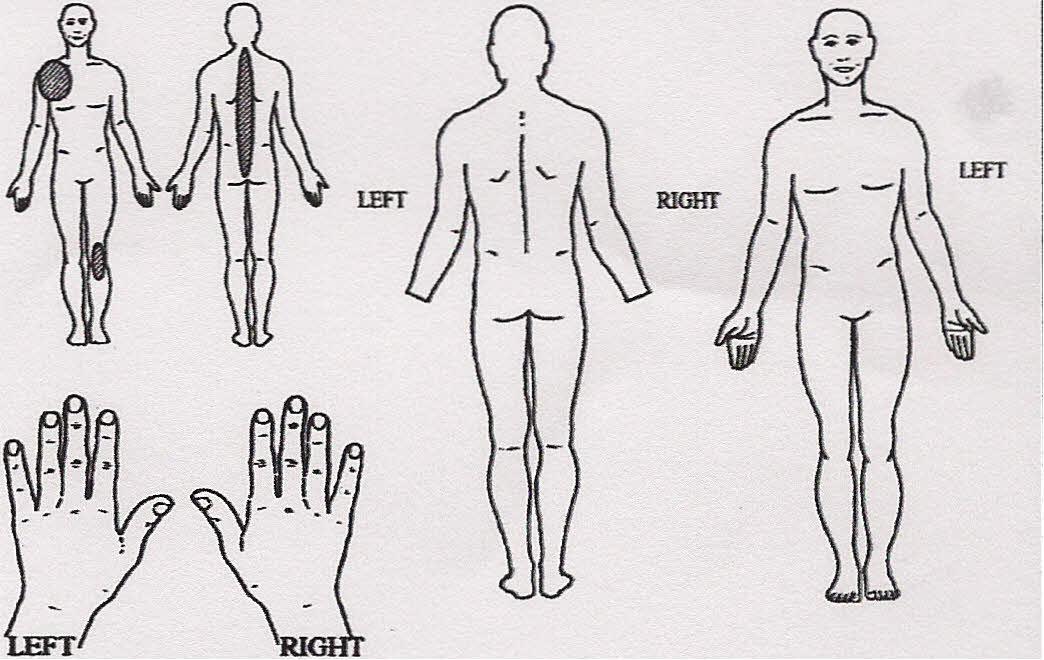
**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

1 2 3 4

o Friend

o Doctor

o Other Health Professional

Example:

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

Adapted from CUNHAQ, Wolle F and PinaJS T. CUrrent

Comment- Uslening to the patient - A   
practical guide fD self report ~onnaires in dinical care. Arthritis Rheum. 1999;42 (9):1797-   
808. Used by pemission.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| At any time have YOU or a blood relative had any of the following? (check if "yes") | | | |  |  |
| Yourself |  | Relative | Yourself |  | Relative |
|  |  | Name/Relationship |  |  | Name/Relationship |
|  | Arthritis (unknown type) |  |  | Lupus or "SLE" |  |
|  | Osteoarthritis |  |  | Rheumatoid Arthritis |  |
|  | Gout |  |  | Ankylosing Spondylitis |  |
|  | Childhood arthritis |  |  | Osteoporosis |  |
| Other arthritis conditions: | |  |  |  |  |

Patient's Name ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Physician Initials.\_\_\_\_\_\_\_\_\_\_

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o Never Married

o Divorced

o Separated

o Widowed

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**SYSTEMS REVIEW**

As you review the following list, please check any of those 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**

o Recent weight gain

Amount

o 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 in swallowing   
  **Cardiovascular**
* Pain in chest
* Irregular heart beat
* Sudden changes in heart beat
* High blood pressure
* Heart murmurs   
  **Respiratory**
* Shortness of breath
* Difficulty in breathing at night
* Swollen legs or feet
* Cough
* Coughing of blood
* Wheezing (asthma)

**Gastrointestinal**

* Nausea
* Vomiting of blood or coffee ground

Mater ial

* 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? 0 Yes 0 No

How many days apart? \_

Date of last period? \_\_\_\_\_/ \_\_\_\_/\_\_\_\_\_

Date of last pap? \_\_\_\_\_/ \_\_\_\_/\_\_\_\_\_

Bleeding after menopause? 0 Yes 0 No

Number of pregnancies? \_

Number of miscarriages? \_

**Musculoskeletal**

o 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**

o 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

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**SOCIAL HISTORY**

Do you drink caffeinated beverages?

Cups/ glasses per day?

Do you smoke? o Yes o No o Past - How long ago?

Do you drink alcohol? o Yes o No Number per week

Has anyone ever told you to cut down on your drinking?

o Yes o No

Do you use drugs for reasons that are not medical? o Yes o No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? o Yes o No

Type

Amount per week

How many hours of sleep do you get at night?

Do you get enough sleep at night? o Yes o No

PAST MEDICAL HISTORY

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

o Cancer 0 Heart problems 0 Asthma

o Goiter 0 Leukemia 0 Stroke

|  |  |  |
| --- | --- | --- |
| o Cataracts | o Diabetes | o Epilepsy |
| o Nervous breakdown | o Stomach ulcers | o Rheumatic fever |
| o Bad headaches | o Jaundice | o Colitis |
| o Kidney disease | o Pneumonia | o Psoriasis |
| o Anemia | o HIVIAIDS | o High Blood Pressure |
| o Emphysema | o Glaucoma | o Tuberculosis |

Other significant illness (please list) \_

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

Do you wake up feeling rested?

Previous Operations

o Yes o No

|  |  |  |
| --- | --- | --- |
| *Type* | *Year* | *Reason* |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |

Any previous fractures? o No o Yes Describe: \_

Any other serious injuries? o No o 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 of any blood relative who has or had: (check and give relationship)

o Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ o Rheumatic fever \_

o Tuberculosis \_\_\_\_\_\_\_\_\_\_\_ \_

o Leukemia \_

o Stroke \_

o Colitis \_

o High blood pressure \_

o Bleeding tendency \_

o Alcoholism \_

o Epilepsy\_\_\_\_\_\_\_\_\_\_\_ \_

o Asthma \_

o Psoriasis \_

o Diabetes \_

o Goiter \_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Patient's Name\_\_\_\_\_\_\_\_\_\_\_ \_ Date Physician Initial

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**MEDICATIONS**

Drug allergies: o No

o Yes

To What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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** | **How long have** | **Please check: Helped?** | | |
|  | **strength & number of** | **you taken this** | A Lot | **Some** | Not At All |
|  | **pills per day)** | **medication** |  |  |  |
| 1. |  |  | 0 | 0 | 0 |
| 2. |  |  | 0 | 0 | 0 |
| 3. |  |  | 0 | 0 | 0 |
| 4. |  |  | 0 | 0 | 0 |
| 5. |  |  | 0 | 0 | 0 |
| 6. |  |  | 0 | 0 | 0 |
| 7. |  |  | 0 | 0 | 0 |
| 8. |  |  | 0 | 0 | 0 |
| 9. |  |  | 0 | 0 | 0 |
| 10. |  |  | 0 | 0 | 0 |

**PAST MEDICATIONS** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | |  | |  |  |  | |  |  |  | |  |  | |
| **Drug names l Dosage** | | | |  | | | | |
|  |  | |  |
| **Non-Steroidal Anti-inflammatory Drugs (NSAlDs)** | | | | **Circle any you have taken in the past** | |  |  |  | |  |  |  | |  |  | |
| Ansaid (flurbiprofen) | Arthrotec (diclofenac + misoprostil) Aspirin | | | | | AspiriAs | | | | | | Celebrex | | | Clinoril (sulindac) | |
| Daypro (oxaprozin) | Disalcid (salsalate) | | | Dolobid | | | Feldene (piroxicam) | | | | Indocin (indomethacin) | | | | Lodine (etodolac) | |
| Meclomen | | Motrin/IbIbuprofen | | | Nalfon (fenoprofen) | | | | | Naprosyn | | | Oruvail (ketoprofen) | | |
| Tolectin (tolmetin) | Trilisate (choline magnesium trisalicylate) Vioxx | | | | | |  | | | Voltaren (diclofenac) | | | | |  | |
| **Pain Relievers** |  | |  |  |  | |  |  | |  |  |  | |  |  | |
| Acetaminoohen (Tvlenol) |  | |  |  | | | | | | | | | | | |
| Codeine (Vicodin, Tylenol 3) | 3) | |  |
| Proooxvohene lDarvonlDarvocet) | | | |
| Other: |  | |  |
| **Disease Modifvina Antirheumatic Druas (DMARDS)** | | | |  |  | |  |  | |  |  |  | |  |  | |
| Hvdroxvchloroauine (Plauuenil) | | | |  | | | | | | | | | | | |
| Penicillamine (Cunrirnine or Deoen\ | | | |
| Methotrexate (Rheumatrex) |  | |  |
| Azathioprine (lmuran) |  | |  |
| Sulfasalazine (Azulfidine) |  | |  |
| Cvcloohosohamide (Cvtoxan\ | | | |
| Etanercept (Enbrel) |  | |  |
| Infliximab (Remicade) |  | |  |
| Other: |  | |  |

Patient's Name Date Physician Initials \_

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