**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.\_\_\_\_\_\_\_\_\_\_

Patient History Form © 1999 American College of Rheumatology

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

Patient History Form © 1999 American College of Rheumatology

**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

Patient History Form © 1999 American College of Rheumatology

**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 \_

Patient History Form © 1999 American College of Rheumatology

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