

RHEUMATOLOGY

REFERRING MD: _____ DATE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ AGE: _____ SEX: MALE FEMALE

TELEPHONE: (____) _____

MARITAL STATUS Never Married Married Divorced Separated Widowed

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

EDUCATION (Circle highest level attended):

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

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: _____

Do you have an orthopedic surgeon? YES NO If yes, Name: _____

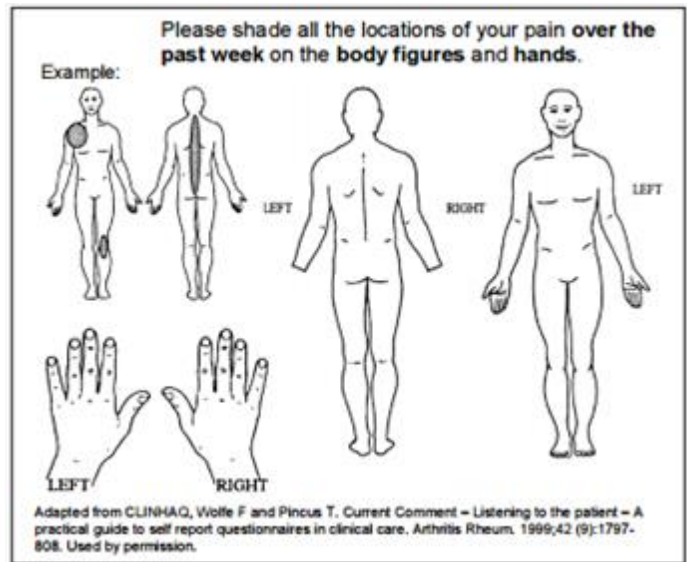
Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, Surgery and injection; medications to be listed later)

Please list the names of other practitioners you have seen for This problem:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	YOURSELF	RELATIVE NAME/ RELATIONSHIP		YOURSELF	RELATIVE NAME/ RELATIONSHIP
Arthritis (unknown type)			Lupus or "SLE"		
Osteoarthritis			Rheumatoid Arthritis		
Gout			Ankylosing Spondylitis		
Childhood arthritis			Osteoporosis		
Other arthritis conditions:					

Physician Initials _____

PATIENT NAME: _____

DOB: _____

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

- 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 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 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
Last in how long?
_____ Minutes _____ Hours
- Joint pain
- Muscle weakness
- Joint swelling
List joint affected in the last 6 mons.

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 NAME: _____

DOB: _____

SOCIAL HISTORY

Do you drink caffeinated beverages? YES NO

If yes, 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 a night? _____

Do you get enough sleep at night? YES NO

Do you wake up feeling rested? YES NO

PAST MEDICAL HISTORY

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

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

Other significant illness (please list) _____

Natural of Alternative Therapies (chiropractic, magnets, massage, Over-the-counter preparations, etc.)

Previous Operations

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 of any blood relative who has or had: (check and five relationship)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Goiter _____ | <input type="checkbox"/> Psoriasis _____ | |

Physician Initials _____

PATIENT NAME: _____

DOB: _____

MEDICATIONS

Drug allergies: NO 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 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/Dosage	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"/>	
Circle any you have taken in the past					
Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<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)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytosan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<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 NAME: _____

DOB: _____

Past Medications, Continued

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risendronate (Actonel)		<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 (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<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 (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<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:

Physician Initials _____

PATIENT NAME: _____

DOB: _____

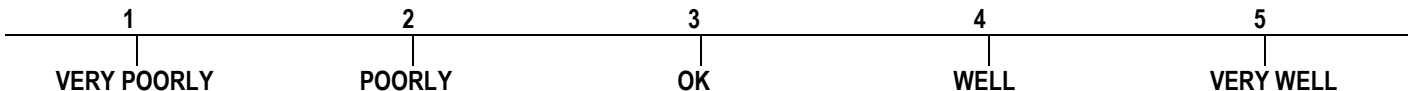
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? : NO YES 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)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, a walker or a wheelchair? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the hardest thing for you to do? _____			
	Yes	No	
Are you receiving disability?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you applying for disability?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a medically related lawsuit pending?	<input type="checkbox"/>	<input type="checkbox"/>	

Physician Initials _____