

Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____
Last First Middle Initial Maiden Month/Day/Year

Address: _____ Age: _____ Sex: F M
Street Apt. #

Telephone: Home _____ Work _____
City State Zip

MARITAL STATUS: Never Married Married Divorced Separated Widowed
 Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses: _____

EDUCATION (circle highest level attended):
 Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

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:

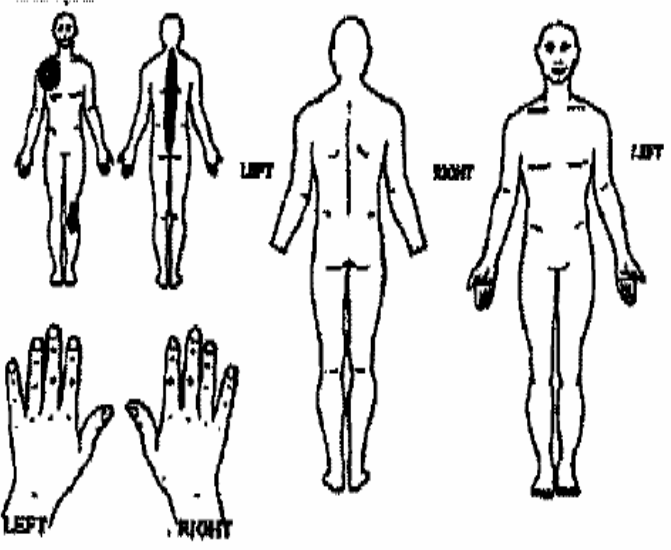
Date symptoms began (approximately): _____

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:

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



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
<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

Other arthritis conditions: _____

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
- 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
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

- Excessive thirst

Hematologic / Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when _____

Allergic / Immunologic

- Frequent sneezing
- Increased susceptibility to infection

SOCIAL HISTORY

Do you drink caffeinated beverages? Yes No
 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: _____

Have you ever been a victim of abuse or neglect? Yes No

Do you exercise regularly? Yes No
 Type _____
 Amount per week _____

How many hours of sleep do you get at 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")

Cancer Heart problems Asthma

Goiter Leukemia Stroke

Cataracts Diabetes Epilepsy

Nervous breakdown Stomach ulcers Rheumatic fever

Bad headaches Jaundice Colitis

Kidney disease Pneumonia Psoriasis

Anemia HIV / AIDS High Blood Press

Emphysema Glaucoma Tuberculosis

Other significant illnesses (please list) _____

Natural or 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: _____

Health of children: _____

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

Cancer _____ Heart disease _____ Rheumatic fever _____ Tuberculosis _____

Leukemia _____ High blood pressure _____ Epilepsy _____ Diabetes _____

Stroke _____ Bleeding tendency _____ Asthma _____ Goiter _____

Colitis _____ Alcoholism _____ Psoriasis _____

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					
Ansaid (flurbiprofen)	Arthrotec (diclofenac + misoprostol)	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)	Oruvall (ketoprofen)	
Tolectin (tolmetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac ophthalmic)		
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"/>	

PAST MEDICATIONS Continued

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"/>
Risedronate (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 (Benamid)	<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 (Nolvex)	<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"/>
Hyalgon (Synvisc)	<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:

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? Yes No 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...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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, as walker or a wheelchair? (circle one) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the hardest thing for you to do? _____			
Are you receiving disability? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you applying for disability? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you have a medically related lawsuit pending? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	