ATLANTA RHEUMATOLOGY CONSULTANTS

Patient History Form

Date of first appointment: _____/_____/_____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate _____/_____/_____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age:_____ Sex: ☐F ☐M - SSN_____
Street Apt #

_____ Telephone: Home (_____) _____
City State Zip Work (_____) _____

Email: _____

Emergency Contact: Name_____ Phone: _____
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 our primary medical care: _____

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

Describe briefly your present symptoms: _____
_____
_____
_____

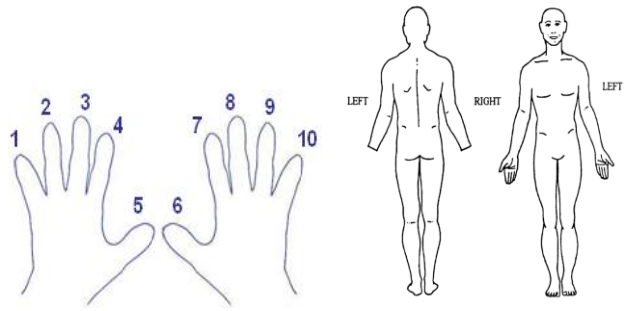
Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and 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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any problems that 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
- ☐ Prostrate trouble

For Women Only:

Age when periods began: _____

Regular periods? ☐ 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? _____min ____ hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint Swelling

List joints affected in the last 6 months:

_____

_____

_____

_____

_____

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's Name _____ Date _____ Physician Initials _____

Social History

Do you drink caffeinated beverages?

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 at night? _____

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

Do you wake 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 Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list: _____

_____

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

_____

_____

PREVIOUS OPERATIONS

Type	Year	Reason

Any Previous Fractures? ☐ Yes ☐ No - Describe: _____

Any other Serious Injuries ☐ Yes ☐ No - 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 that has had 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

Patient's Name _____ Date _____ Physician Initials _____

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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

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 A Lot	Some	Not At All	Reactions
Non-Steriodial Anti-Imflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past – Ansaid (fluriprofen) 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)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Colum		☐	☐	☐	
Other:		☐	☐	☐	
Other		☐	☐	☐	

Patient's Name _____ Date _____ Physician Initials _____