Text

Description automatically generated

Date of first appointment:

/

**month**

**day**

/ Time of appointment:

**year**

Birthplace:

Name: last first middle initial maiden Birthdate:

/

month

day

/

year

Address:

street

Age

Sex:  F  M

city state zip

Telephone: Home: ( ) Work: ( )

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Full Time**   **Part Time**   **Retired**

**MARITAL STATUS: ** Never Married  Married  Divorced  Separated  Widowed

Spouse/Significant Other:  Alive/Age 

*(Circle your criteria from each section below):*

Deceased/Age Major Illnesses:

**Race**: American Indian or Alaska Native, Asian, Black or African American, Caucasian/White, Native Hawaiian or Other Pacific Islander, Multiracial, Refused/Decline or Unknown

**Ethnicity**: Hispanic or Latino, Not Hispanic or Latino, Refused/Declined or Unknown

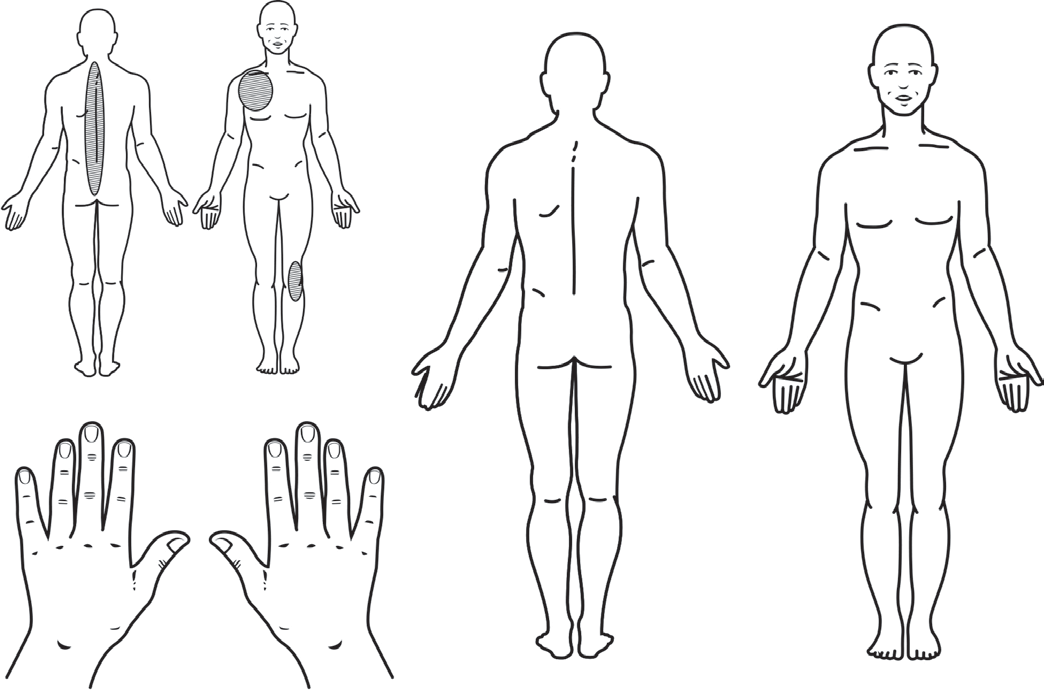
**Preferred Language**: English, Spanish, Refused/Decline or Unknown

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: 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):*



Example:

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

LEFT

RIGHT

LEFT

LEFT

RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

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

# SYSTEMS REVIEW

As you review the following list, please check any 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 swallowing

## Cardiovascular

 Chest Pain

 Irregular heart beat

 Sudden changes in heart beat  High blood pressure

 Heart murmurs

## Respiratory

 Shortness of breath

 Difficulty 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 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?

# PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check 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:*

 Cancer  MS

CHF



 Depression

 Kidney disease  Blood Clot (DVT/PE)

 COPD/ Emphysema

 Heart problems  Leukemia

 Diabetes

 Stomach ulcers  Diverticulitis

 Pneumonia  Fracture

 Glaucoma

 Asthma  Stroke  Crohn’s

 Ulcerative Colitis

 Psoriasis

 High Blood Pressure  Tuberculosis

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

Other significant illness *(please list)*

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

# PREVIOUS SURGERIES

|  |  |  |
| --- | --- | --- |
| **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 of children Number living

Number deceased Number deceased

List ages of each

\_\_\_

\_\_\_

\_\_\_

\_\_\_

\_\_\_

Health of children

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

 Thyroid Disease  Multiple Sclerosis  Crohn’s Ulcerative Colitis

 Rheumatoid Arthritis  Lupus (SLE)  Psoriasis Psoriatic Arthritis

 Heart Disease  Stroke Asthma Psoriasis

 Tuberculosis  Type 1 Diabetes Ankylosing Spondylitis

 Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MEDICATIONS

**Drug allergies: ** No  Yes If yes, please list:

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/Dose** | **Length of time** | **Please check: Helped?**  A Lot Some Not At All | | | **Reactions** |
| Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) |  |  |  |  |  |
| *Circle any you have taken in the past*  Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate  Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac | | | | | |
| **Pain Relievers** | | | | | |
| Acetaminophen |  |  |  |  |  |
| Codeine |  |  |  |  |  |
| Propoxyphene |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| **Disease Modifying Antirheumatic Drugs (DMArDS)** | | | | | |
| Certolizumab |  |  |  |  |  |
| Golimumab |  |  |  |  |  |
| Hydroxychloroquine |  |  |  |  |  |
| Penicillamine |  |  |  |  |  |
| Methotrexate |  |  |  |  |  |
| Azathioprine |  |  |  |  |  |
| Sulfasalazine |  |  |  |  |  |
| Quinacrine |  |  |  |  |  |
| Cyclophosphamide |  |  |  |  |  |
| Cyclosporine A |  |  |  |  |  |
| Etanercept |  |  |  |  |  |
| Infliximab |  |  |  |  |  |
| Tocilizumab |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |

**PAST MEDICATIONS** *Continued*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug names/Dose** | **Length of time** | **Please check: Helped?** | | | **Reactions** |
| A Lot | Some | Not At All |
| **Osteoporosis Medications** | | | | | |
| Estrogen |  |  |  |  |  |
| Alendronate |  |  |  |  |  |
| Etidronate |  |  |  |  |  |
| Raloxifene |  |  |  |  |  |
| Fluoride |  |  |  |  |  |
| Calcitonin injection or nasal |  |  |  |  |  |
| Risedronate |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| **Gout Medications** | | | | | |
| Probenecid |  |  |  |  |  |
| Colchicine |  |  |  |  |  |
| Allopurinol |  |  |  |  |  |
| Other: |  |  |  |  |  |
| Other: |  |  |  |  |  |
| **Others** | | | | | |
| Tamoxifen |  |  |  |  |  |
| Tiludronate |  |  |  |  |  |
| Cortisone/Prednisone |  |  |  |  |  |
| Hyaluronan |  |  |  |  |  |
| Herbal or Nutritional Supplements |  |  |  |  |  |

*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 | OK | WELL | VERY |
| POORLY |  |  |  | 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? ........................................................................................................................

Walking? ............................................................................................................................................................................

Climbing stairs? .....................................................................................................................................................................................

Descending stairs?..............................................................................................................................................................

Sitting down?.....................................................................................................................................................................

Getting up from chair?.................................................................................................................................................................

Touching your feet while seated? ..........................................................................................................................................................

Reaching behind your back? ..................................................................................................................................................................

Dressing yourself? ..................................................................................................................................................................................

Going to sleep? ......................................................................................................................................................................................

Staying asleep due to pain? ..................................................................................................................................................................

Obtaining restful sleep?...............................................................................................................................................................

Bathing?..........................................................................................................................................................................

Eating?............................................................................................................................................................................

Working? ............................................................................................................................................................................

Getting along with family members?...........................................................................................................................................

In your sexual relationship? ...................................................................................................................................................................

Engaging in leisure time activities?........................................................................................................................................................

With morning stiffness.................................................................................................................................................................

Do you use a cane, crutches, walker or wheelchair? *(circle one)* .........................................................................................................

What is the hardest thing for you to do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving disability? ........................................................................................................................................................Yes  No 

Are you applying for disability?....................................................................................................................................................Yes  No 

Do you have a medically related lawsuit pending? ......................................................................................................................Yes  No 