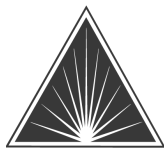

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ______/_____/_____ (MONTH DAY YEAR) Time of appointment: __________ Birthplace: ____________________

Name: ________________________________ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: _____/______/______ (MONTH DAY YEAR)

Address: ________________________________ (STREET APT#) Age: __________ Sex: ❑ F ❑ M

________________________________ (CITY STATE ZIP) Telephone: Home (______)________________
Work (______)________________

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 (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**.

Example:

Example

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.

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:					

Patient's Name ______________________ Date ______________________ Physician Initials _______

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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
  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

Patient’s Name ________________________________ Date ____________________________ Physician Initials ________

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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 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 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***
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 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 ______

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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?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (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)		❑	❑	❑	
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)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name ____________________ Date ____________________ Physician Initials ________

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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: ______________________________

Patient's Name ____________________ Date ____________________ Physician Initials ________

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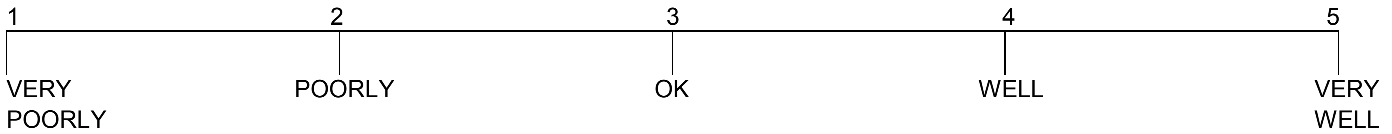
ACTIVITIES OF DAILY LIVING

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…*



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.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
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, as walker or a 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 ❑

Patient's Name ______________________________ Date _________________________ Physician Initials _______

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