

RHEUMATOLOGY ASSOCIATES

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Dallas, TX 75231 214 540-0700

Patient History Form

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

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

Address: _____ Age: _____ Sex: F M
STREET APT#

CITY STATE ZIP Telephone: Home (_____) _____
Work (_____) _____

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): _____

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:

Diagnosis given: _____

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

Example:

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.

RHEUMATIC DISEASE (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 |
| <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | Chronic fatigue syndrome |
| Other arthritis conditions: _____ | | | |

Patient's Name _____ Date _____ Physician Initials _____

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 ____ / ____ / ____

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ Minutes _____ Hours

- Joint pain
 - Joint swelling
- List joints affected in the last 6 mos.

- Muscle weakness
- Muscle tenderness

Constitutional

- Generalized weakness
- Fatigue
- Fever or chills
- Night sweats
- Recent weight loss
amount _____
- Recent weight gain
amount _____

Eyes

- Dryness
- Loss of vision
- Redness
- Feels like something in eye
- Pain
- Double or blurred vision
- Itching eyes

Dermatology

- Thickness
- Tightness
- Rash
- Unexpected hair loss
- Sun sensitive (sun allergy)
- Redness
- Hives
- Nodules/bumps
- Nail pits
- Tattoos

Psychiatric

- Depression
- Difficulty falling asleep
- Difficulty staying asleep
- Excessive worries
- Anxiety
- Panic attacks
- Easily losing temper
- Agitation

Gastrointestinal

- Nausea
- Vomiting
- Abdominal pain
- Heartburn
- Diarrhea
- Increasing constipation
- Mucus in stools
- Blood in stools
- Black stools
- Jaundice

Genitourinary

- Discharge from penis/vagina
- Rash, ulcers, or sores
- Pain or burning on urination
- Difficulty in urination
- Blood in urine
- Cloudy, "smoky" urine
- Getting up at night to pass urine
- Vaginal dryness
- 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? _____

Respiratory

- Shortness of breath
- Cough
- Coughing of blood
- Wheezing (asthma)

Neurological System

- Headaches
- Numbness or tingling in hands
- Numbness or tingling in feet
- Muscle spasm
- Dizziness
- Fainting
- Loss of consciousness
- Memory loss

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen lymph nodes
- Bleeding tendency
- Easy bruising
- Tender glands
- Blood clot in artery, vein, or lung
- Transfusion/when _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Ears–Nose–Mouth–Throat

- Difficulty in swallowing
- Dryness of mouth
- Sores in mouth
- Sinus pain
- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Sore tongue
- Bleeding gums
- Loss of taste
- Frequent sore throats
- Hoarseness

Cardiovascular

- Pain in chest
- Cramping in calves when walking
- Color changes of hands in the cold
- Difficulty in breathing at night
- Swollen legs or feet
- Irregular heart beat
- Sudden changes in heart beat
- Heart murmurs

YOUR PAST MEDICAL HISTORY: Have **YOU** ever been diagnosed with any of the following diseases?

- | | | | | | |
|--|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer/Leukemia/Lyphoma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema/COPD/Asthma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Sarcoidosis |

Other significant illness (not listed above): _____

Previous Operations/ Surgical History

| 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 sisters ____ Number living ____ Number deceased ____ Number of brothers ____ Number living ____ Number deceased ____

Number of daughters ____ Number living ____ Number deceased ____ Number of sons ____ Number living ____ Number deceased ____

Health of children: _____

Do you know of any close blood relative (parent, sibling or child) who has or had: (check and give relationship)

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

SOCIAL HISTORY:

Marital Status: Never Married Married Divorced Separated Widowed

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

How many people in household? _____ Relationship and age of each _____

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 _____

Do you drink caffeinated beverage? No Yes Cups/glasses per day? _____

Do you smoke? No Yes Previous smoker How long ago? _____

Do you drink alcohol? No Yes Number per week _____ Has anyone ever told you to cut down on your drinking? No Yes

Recreational drug use? No Yes If yes please list _____

Do you have stairs to climb? Yes No If yes, how many? ____

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 OVER THE COUNTER MEDICINES 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) | | | | | |
| Ansaid (flurbiprofen) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthrotec (diclofenac + misoprostil) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Aspirin (including coated aspirin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bextra (valdecoxib) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Celebrex (celecoxib) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Daypro (oxaprozin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Disalcid (salsalate) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dolobid (diflunisal) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Feldene (piroxicam) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Indocin (indomethacin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lodine (etodolac) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Meclomen (meclofenamate) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Mobic (meloxicam) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Motrin (ibuprofen) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nalfon (fenoprofen) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Naprosyn (naproxen) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Oruvail (ketoprofen) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tolectin (tolmetin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Trilisate (choline magnesium trisalicylate) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vioxx (rofecoxib) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Voltaren (diclofenac) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pain Relievers | | | | | |
| Acetaminophen (Tylenol) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Codeine (Tylenol 3) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Propoxyphene (Darvon/Darvocet) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hydrocodone (Vicodin, Lortab, Norco) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ultram/Ultracet (tramadol) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

| Drug names/Dosage | Length of time | Please check: Helped? | | | Reactions |
|---|----------------|--------------------------|--------------------------|--------------------------|-----------|
| | | A Lot | Some | Not At All | |
| Corticosteroids | | | | | |
| Decadron (dexamethasone) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Medrol dose pack (methylprednisolone) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Prednisone | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cortisone injection (where) _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Disease Modifying Antirheumatic Drugs (DMARDS) | | | | | |
| Arava (leflunomide) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Atabrine (quinacrine) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Azulfidine (sulfasalazine) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CellCept (mycophenolate mofetil) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cimzia (certolizumab) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cuprimine or Depen (Penicillamine) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cytoxan (cyclophosphamide) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Enbrel (Etanercept) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gold shots (Myochrysin or Solganol) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Humira (adalimumab) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Imuran (azathioprine) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kineret (anakinra) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Methotrexate (Rheumatrex) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neoral or Sandimmune (Cyclosporine A) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Orencia (abatacept) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Plaquenil (hydroxychloroquine) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Remicade (Infliximab) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ridaura, gold pills (auranofin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rituxan (rituximab): | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Simponi (golimumab) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Osteoporosis Medications | | | | | |
| Actonel (risedronate) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Boniva | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Estrogen (Premarin, etc.) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Evista (raloxifene) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Forteo (teriparatide) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Fosamax (alendronate) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Miacalcin, (nasal spray) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Reclast (zoledronic acid solution) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gout Medications | | | | | |
| Allopurinol (Zyloprim/Lopurin) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| CoBenemid (colchicine and probenecid) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Colchicine | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Probenecid (Benemid) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Uloric | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Others | | | | | |
| Hyalgan/Synvisc/Orthovisc/Euflexxa injections | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cymbalta | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Lyrica | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Muscle Relaxers | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neurontin | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Savella | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sleep Medication | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other anti-depressants: | | | | | |

Have you participated in any clinical trials for new medications? Yes No If yes, list:

Patient's Name _____ Date _____ Physician Initials _____

ACTIVITIES OF DAILY LIVING

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

Because of health problems do you have difficulty:
(Please check the appropriate response for each question.)

| | Without ANY difficulty | With SOME difficulty | With MUCH difficulty | UNABLE to do |
|---|---------------------------------------|-------------------------------------|-------------------------------------|-------------------------|
| 1. Dress yourself, including tying shoelaces and doing buttons? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 2. Get in and out of bed? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 3. Lift a full cup or glass to your mouth? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 4. Walk outdoors on flat ground? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 5. Wash and dry your entire body? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 6. Bend down to pick up clothing from the floor? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 7. Turn regular faucets on and off? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 8. Get in and out of a car, bus, train, or airplane? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 9. Reaching behind your head? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 10. Reaching behind your back? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 11. Going to sleep? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 12. Staying asleep due to pain? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 13. Obtaining restful sleep? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 14. Climbing stairs? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 15. Descending stairs? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 16. Sitting down? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 17. Working? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 18. Getting along with family members? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 19. In your sexual relationship? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |
| 20. Engaging in leisure time activities? | ___ 0 | ___ 1 | ___ 2 | ___ 3 |

TOTAL HAQ SCORE: _____

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

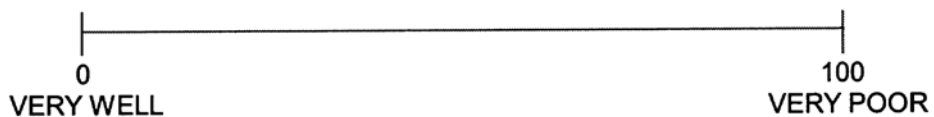
Are you applying for disability?..... Yes No

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

Do you exercise regularly? No Yes Type _____

Amount per week? _____

Considering that all of the ways your arthritis has affected you over the past week, please place a vertical mark on the line below to show how you are feeling:



Patient's Name _____ Date _____ Physician Initials _____