

# RHEUMATOLOGY ASSOCIATES

8144 Walnut Hill Ln., Ste. 800  
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:

LEFT RIGHT LEFT RIGHT

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.

### 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: \_\_\_\_\_

## REVIEW OF SYSTEMS

As you review the following list, please check any of those problems which have significantly affected you.

### 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

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

### Dermatology

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

### Psychiatric

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

### Gastrointestinal

- Nausea  
 Vomiting  
 Abdominal pain  
 Heartburn  
 Diarrhea  
 Mucus in stools  
 Unusual constipation  
 Blood in stools  
 Black/tarry stools

### Genitourinary

- Difficulty urinating  
 Blood in urine  
 Pain or burning on urination  
 Pus in urine  
 Cloudy urine  
 Sexual difficulties  
 Genital rash/ulcers

*For Women Only:*

- Vaginal dryness  
 Vaginal discharge  
Date of last period? \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of pregnancies? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

*For Men Only:*

- Discharge from penis  
 Prostate trouble

### Respiratory

- Shortness of breath  
 Cough  
 Difficulty breathing at night  
 Coughing of blood  
 Wheezing (asthma)

### Neurological System

- Numbness or tingling in hands  
 Numbness or tingling in feet  
 Headaches  
 Dizziness  
 Fainting  
 Muscle spasm  
 Cramping in legs at night  
 Memory loss

### Endocrine

- Excessive thirst

### Hematologic/Lymphatic

- Blood clot in artery, vein, or lung  
 Bleeding tendency  
 Enlarged lymph nodes  
 Anemia  
 Transfusion/when \_\_\_\_\_

### Allergic/Immunologic

- Frequent sneezing  
 Increased susceptibility to infection

### Ears–Nose–Mouth–Throat

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

### Cardiovascular

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

**Please state the date of your last:**

Bone Densitometry \_\_\_\_/\_\_\_\_/\_\_\_\_

Mammogram \_\_\_\_/\_\_\_\_/\_\_\_\_

Eye exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Chest x-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

Tuberculosis Test \_\_\_\_/\_\_\_\_/\_\_\_\_

Flu Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

Pneumonia Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

Tetanus Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

Shingles Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis B Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

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

- |   |  |  |  |   |                                      |
|---|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> Cancer/Leukemia/Lymphoma | <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	
	Year of Birth	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 Amount per day \_\_\_\_\_  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 exercise regularly?**  No  Yes Frequency \_\_\_\_\_ Please describe \_\_\_\_\_

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 Medications as well, 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	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>					
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"/>	
Celebrex (celecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daypro (oxaprozin)		<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"/>	
Mobic (meloxicam)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin (ibuprofen)		<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"/>	
Voltaren (diclofenac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Pain Relievers</b>					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Tylenol 3)		<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"/>	
<b>Corticosteroids</b>					
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"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDS)</b>					
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"/>	

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

<b>DMARDS - Continued</b>					
Cytoxan (cyclophosphamide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Imuran (azathioprine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Methotrexate (rheumatex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neoral or Sandimmune (Cyclosporine A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Plaquenil (hydroxychloroquine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Biologics</b>					
Actemra (tocilizumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cimzia (certolizumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Enbrel (etanercept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Humira (adalimumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kineret (anakinra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Orencia (abatacept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Remicade (Infliximab)	<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"/>		
<b>Osteoporosis Medications</b>					
Actonel (risedronate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Boniva (ibandronate)	<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 (calcitonin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prolia (denosumab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Reclast (zoledronic acid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Gout Medications</b>					
Zyloprim (allopurinol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colcrys (colchicine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Benemid (probenecid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Uloric (febuxostat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Krystexxa (pegloticase)					
<b>Others</b>					
Hyalgan/Synvisc/Orthovisc/Euflexxa injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cymbalta (duloxetine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lyrica (pregabalin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neurontin (gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Savella (milnacipran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle Relaxers	<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. Working?	___ 0	___ 1	___ 2	___ 3
17. Getting along with family members?	___ 0	___ 1	___ 2	___ 3
18. Engaging in leisure time activities?	___ 0	___ 1	___ 2	___ 3

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

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

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

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

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

**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:**

VERY GOOD    0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10    VERY POOR

**How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle on line below.**

NO PROBLEM    0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10    MAJOR PROBLEM

**How much pain have you had because of your condition OVER THE PAST WEEK? Please circle on the line below.**

NONE    0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10    AS BAD AS IT COULD BE

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_