

Triangle Orthopaedic Associates, P.A.

Rheumatology Patient History Form

Name: _____ Birthdate: ____/____/____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR
 Address: _____ Age: _____ Sex: F M
STREET APT#
 Telephone: Home (____) _____
CITY STATE ZIP Cell (____) _____

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: _____

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.

PAST MEDICAL HISTORY
 Do you now or have you ever had (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Colitis	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Tuberculosis		

Other significant illness (please list) _____

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

Social History
 Do you drink caffeine? Yes No How many per day? _____
 Do you smoke? Yes No Past - How long ago? _____
 Do you drink alcohol? Yes No Number per week _____
 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? _____

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

Name _____ DOB _____

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? No Yes Describe: _____

FAMILY HISTORY:

	MOTHER	FATHER		MOTHER	FATHER
ARTHRITIS	Y	N	DIABETES	Y	N
KIDNEY DISEASE	Y	N	BLEEDING PROBLEMS	Y	N
HEART DISEASE	Y	N	STROKE	Y	N
CANCER	Y	N	HIGH BLOOD PRESSURE	Y	N
OTHER _____	Y	N	ANKYLOSING SPONDYLITIS	Y	N
OSTEOARTHRITIS	Y	N	CHILDHOOD ARTHRITIS	Y	N
RHEUMATOID ARTHRITIS	Y	N	OSTEOPOROSIS	Y	N

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

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.				<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"/>

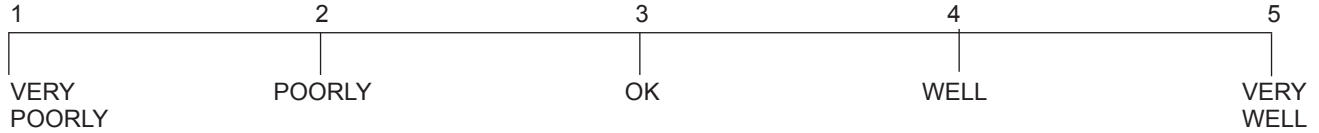
ACTIVITIES OF DAILY LIVING

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, a walker or a wheelchair? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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