



AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

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 ()

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): _____ **Example**

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:

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")

Yourselves	Relative Name/Relationship	Yourselves	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

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 ____ / ____ / ____

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 _____

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

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 _____	

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.) _____
