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):________________

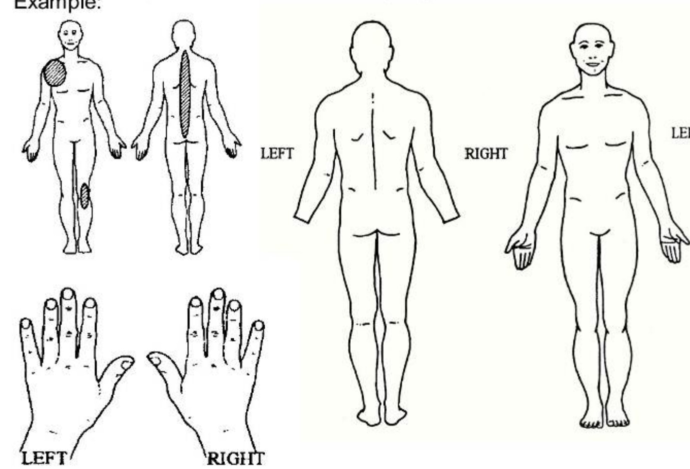
Diagnosis:____________________________________

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:



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 ________

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

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 ________

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? A Lot	Some	Not At All	Reactions
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 ________

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 ________

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…*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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 ______