



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:

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.

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

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 _____

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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"/>

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)					
<p>Circle any you have taken in the past</p> <p> Ansaïd (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) </p>					
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

Have you participated in any clinical trials for new medications? Yes No

If yes, list:

Patient's Name _____ Date _____ Physician Initials _____

