AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ○ F ○ M
STREET APT#

_____ Telephone: Home _____
CITY STATE ZIP Work _____

MARITAL STATUS: ○ Never Married ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse/Significant Other: ○ Alive/Age _____ ○ Deceased/Age _____ Major Illnesses _____

EDUCATION (select 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): _____

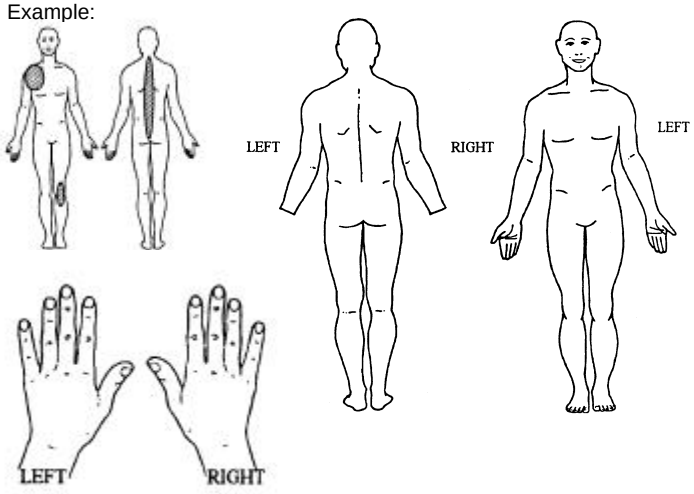
Diagnosis: _____

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:



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 caffinated 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 (chiropracty, 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:		☐	☐	☐	

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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal (Miacalcin, Calcimar)		☐	☐	☐	
Residronate (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 _____