

Date of first appointment: _____ / _____ / _____ Birthplace: _____
Name: _____ Birthdate: _____ / _____ / _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR
Address: _____ Age: _____ Sex: F M
STREET APT.# CITY STATE ZIP Telephone: Home () _____
Work () _____

Referred here by: (check one)
 Self Family Friend Doctor Other health professional

Name of the person making referral: _____
Name of the physician providing your general medical care: _____

Do you have an orthopedic surgeon? Yes No; If yes, name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____ Diagnosis given (please list): _____

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: _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following (check if "yes")?

You	Relative (name/relationship)	You	Relative (name/relationship)
_____ Arthritis (type unknown)	_____	_____ Lupus or "SLE"	_____
_____ Osteoarthritis	_____	_____ Ankylosing spondylitis	_____
_____ Rheumatoid arthritis	_____	_____ Childhood arthritis	_____
_____ Gout	_____	_____ Osteoporosis	_____

Other arthritis conditions: _____

SYSTEMS REVIEW

As you review the following list, please check any problems which apply to you.

GENERAL:

- _____ Recent weight gain/amount _____
- _____ Recent weight loss/amount _____
- _____ Fatigue
- _____ Weakness
- _____ Fever

NERVOUS SYSTEM:

- _____ Headaches
- _____ Dizziness
- _____ Fainting
- _____ Muscle spasm
- _____ Loss of consciousness
- _____ Sensitivity or pain of hands and/or feet
- _____ Memory loss

EARS:

- _____ Ringing in ears
- _____ Loss of hearing

EYES:

- _____ Pain
- _____ Redness
- _____ Loss of vision
- _____ Double or blurred vision
- _____ Dryness
- _____ Feels like something in eye

NOSE:

- _____ Nosebleeds
- _____ Loss of smell
- _____ Dryness

MOUTH:

- _____ Sore tongue
- _____ Bleeding gums
- _____ Sores in mouth
- _____ Loss of taste
- _____ Dryness

THROAT:

- _____ Frequent sore throats
- _____ Hoarseness
- _____ Difficulty in swallowing

NECK:

- _____ Swollen glands
- _____ Tender glands

HEART AND LUNGS:

- _____ Pain in chest
- _____ Irregular heart beat
- _____ Sudden changes in heart beat
- _____ Shortness of breath
- _____ Difficulty in breathing at night
- _____ Swollen legs or feet
- _____ High blood pressure
- _____ Heart murmurs
- _____ Cough
- _____ Coughing of blood
- _____ Wheezing
- _____ Night sweats

STOMACH AND INTESTINES:

- _____ Nausea
- _____ Vomiting of blood or "coffee-ground" material
- _____ Stomach pain relieved by food or milk
- _____ Yellow jaundice
- _____ Increasing constipation
- _____ Persistent diarrhea
- _____ Blood in stools
- _____ Black stools
- _____ Heartburn

KIDNEY/URINE/BLADDER:

- _____ Difficult urination
- _____ Pain or burning on urination
- _____ Blood in urine
- _____ Cloudy, "smoky" urine
- _____ Pus in urine
- _____ Discharge from penis/vagina
- _____ Frequent urination
- _____ Getting up at night to pass urine
- _____ Vaginal dryness
- _____ Rash/ulcers
- _____ Sexual difficulties
- _____ Prostate trouble

BLOOD:

- _____ Anemia
- _____ Bleeding tendency

- _____ Date of last eye examination
- _____ Date of last chest x-ray
- _____ Date of last tuberculosis test

SKIN:

- _____ Easy bruising
- _____ Redness
- _____ Rash
- _____ Hives
- _____ Sun sensitive (sun allergy)
- _____ Tightness
- _____ Nodules/bumps
- _____ Hair loss
- _____ Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES:

- _____ Morning stiffness
- _____ Lasting how long:
 - _____ Minutes
 - _____ Hours
- _____ Joint pain
- _____ Muscle weakness
- _____ Muscle tenderness
- _____ Joint swelling:

List joints affected in the last 6 months:

HABITS:

- Do you drink coffee? Yes No
- Cups per day? _____
- Do you smoke? Yes No Past
- Cigarettes per day? _____
- Has anyone ever told you to cut down on your drinking? Yes No
- Do you use drugs for reasons that are not medical? If so, please list:

How many pillows do you use to sleep on each night? _____

Do you get enough sleep at night?

- Yes No

Do you wake up feeling rested?

- Yes No

MENSTRUAL:

Age when periods began: _____ Periods regular? Yes No How many days apart? _____ Date of last period: ___/___/___

Date of last Pap smear: ___/___/___ Bleeding after menopause: _____

PAST PERSONAL HISTORY:

Do you or have you had any of the following (*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 _____

Other significant illness (please list) _____

Previous Operations:

Type	Year	Surgeon	City
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____

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 Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of children _____ Number Living _____ Number Deceased _____ List ages of each _____

Serious illnesses 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 _____

MARITAL STATUS:

Never Married Married Divorced Separated

Spouse: _____ Alive/Age _____ Deceased/Age at death _____ Major illnesses: _____

MEDICATIONS

DRUG ALLERGIES: No Yes To what? _____

Type of reaction? _____

Present: (List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

	Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Helpful?		
				A lot	Some	Not at all
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Past: 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 Name/Dosage	Length of Time	Helpful?			Reactions
		A lot	Some	Not at all	
1. Aspirin					
2. Aspirin-containing product					
3. Easprin					
4. Disalcid					
5. Tylenol (plain)					
6. Tylenol with codeine					
7. Darvon/Darvocet					
8. Clinoril					
9. Feldene					
10. Indocin					
11. Meclomen					
12. Motrin/Rufen					
13. Nalfon					
14. Naprosyn					
15. Tolectin					
16. Cortisone/Prednisone					
17. Benemid					
18. Colchicine					
19. Zylprim/Lopurin					
20. Gold (shots or pills)					
21. Plaquenil					
22. Penicillamine					
23. Methotrexate					
24. Imuran					
25. Cytoxan					
26. Other					
27. Other					
28. Other					