



# 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:

\_\_\_\_\_

\_\_\_\_\_

### 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
<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: \_\_\_\_\_

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.

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  NoDo 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  NoDo 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 \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

**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.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<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 (dflunisal)    Feidene (piroxicam)    Indocin (indomethacin)    Lodine (etodolac)                      Meclomen (meclofenamate)    Motrin/Rufen (ibuprofen)    Nalfon (fenoprofen)    Naprosyn (naproxen)    Oruvail (ketoprofen)                      Tolectin (tolmetin)    Trilisate (choline magnesium trisalcylate)    Vioxx (rofecoxib)    Voltaren (diclofenac)                 </p>					
<b>Pain Relievers</b>					
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"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDS)</b>					
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"/>	
Prosurba 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"/>	

**PAST MEDICATIONS Continued**

<b>Osteoporosis Medications</b>					
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"/>	
<b>Gout Medications</b>					
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"/>	
<b>Others</b>					
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:

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Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

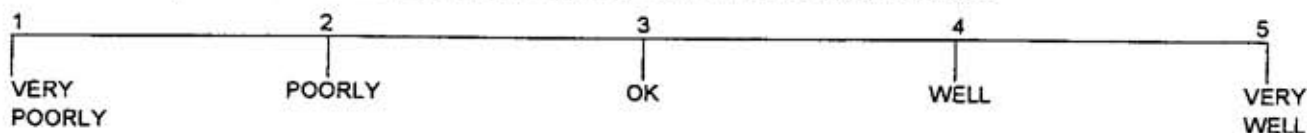
## ACTIVITIES OF DAILY LIVING

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...*



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.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, as walker or a wheelchair? (circle one).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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