Arthritis & Autoimmunity Clinic

MEDICAL HISTORY FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

CHIEF COMPLAINT / REASON FOR VISIT: _____

PLEASE CHECK BOXES NEXT TO SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 12 MONTHS.

☐	General
	weight loss _____lbs
	weight gain _____lbs
	fever
	night sweats
	fatigue

☐	Eyes
	pain
	redness
	dryness
	recent vision change

☐	Ear / Nose Mouth / Throat
	hearing loss
	nosebleed

☐	Heart
	chest pain
	leg swelling
	palpitations

☐	Stomach/Intestines
	nausea
	vomiting
	heartburn
	constipation
	loose stools
	watery diarrhea
	blood in stools
	black stools

☐	Kidney / Urine / Bladder
	painful urination

☐	Nervous System
	headaches
	numbness/tingling in hands/feet
	walking difficulty

☐	Skin
	rash
	nodules/bumps
	purplish/white color changes on the tips of fingers
	redness with brief exposure to the sun
	hair loss: ___years ___months

☐	Psychiatric
	depression; medications used: _____ ___
	anxiety/nervousness

	hoarse voice
	dry mouth
	mouth sores
	trouble swallowing

	difficulty urinating
	frequent urination
	blood in urine
	vaginal dryness
	genital ulcers/rash

	sleep problems

	Lungs
	shortness of breath
	trouble breathing at night
	dry cough
	cough with sputum

	Blood
	anemia
	easy bleeding
	previous blood clots

	For Women Only
	age when periods began: _____
	regular period, every _____ days
	irregular period, every _____ days
	# of pregnancies _____
	# of miscarriages _____
	menopause at age _____
	contraception: ❑ none ❑ IUD ❑ birth control pills ❑ tubal ligation ❑ other _____

PREVIOUS TREATMENT / INJECTIONS FOR PAIN

Previous Joint Injections

- Joint _____ month-year _____
- Joint _____ month-year _____
- Joint _____ month-year _____

Previous Epidural Injections

- Cervical month-year _____
- Lumbar month-year _____

Previous Physical Therapy

- Acupuncture

- Massage therapy
- Other alternative treatment _____

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction**: ex: Nausea

Medication List: (please list all medications including over-the-counter medications you currently take)

Prescription Medications	**Dosage or Strength** Examples: 500 mg, 25 mg/mL, etc.	**Route** Examples: by mouth, patch, injection, etc.	**Frequency (How often you take medication)** Examples: twice a day, every 2 hours, etc.

Medication used: Please check medication you have tried/used:

	Acetaminophen		Aleve
	Aspirin		Diclofenac
	Ibuprofen		Meloxicam
	Mobic		Motrin
	Naproxen		Tylenol
	Voltaren		Arava / Leflunomide
	Cellcept / Mycophenolate		Cytoxan
	Imuran / Azathioprine		Methotrexate
	Plaquenil / Hydroxychloroquine		Rituxan / Rituximab
	Reclast		Prolia
	Evenity		Cymbalta
	Effexor / Venlafaxine		Gabapentin
	Lyrica		Savella
	Tramadol		Baclofen
	Carisoprodol / Soma		Flexeril / Cyclobenzaprine
	Methocarbamal / Robaxin		Tizanidine / Zanaflex
	Dilaudid		Hydrocodone / Norco / Vicodin
	Morphine / Fentanyl patches		Oxycodone / Percocet
	Tylenol with codeine		Xeljanz
	Rinvoq		Sulfasalazine
	Otezla		

Self-injectables: Example, Humira, Enbrel

List:

_____

_____

Infusion: Example: Infliximab/Remicade

List:

_____

Other:

_____

PREVIOUS RHEUMATOLOGIST

Name:

_____

Address/Facility:

_____

Phone # _____

Fax #: _____

CURRENT PCP:

Name:

_____

Address/Facility:

_____

Phone # _____

Fax #: _____

Past Medical History: Please check if you have a history of any condition below

	Alcoholism		Acid Reflux/Stomach Ulcer
	Anemia		Aneurysm/Heart valve Disease
	Any Other		Asthma
	Bleeding/Blood disorder		Blood Clots
	Cancer		Congestive Heart Failure
	COPD		Coronary Artery Disease/M.I
	Crohn's/Ulcerative Colitis		Depression
	Diabetes Mellitus		Diverticulitis
	Eye Disease/Glaucoma		Fibromyalgia
	Fracture		Gout
	H/o fluid around heart/pericardial effusions		H/o fluid in lungs/pleural effusions
	H/o ulcerative colitis		Heart attack
	Hepatitis		Hepatitis C
	High Cholesterol/Hyperlipidemia		High Cholesterol/Hyperlipidemia
	Hypertension		Hypothyroidism
	Kidney Disease		Liver Disease
	Lymphoma/Leukemia		Multiple Sclerosis
	Osteoarthritis		Osteoporosis
	Positive PPD/TB test		Prostate Disorder
	Psoriasis		Pulmonary/Lung Disease
	Seizures		Skin Cancer

	Skin disorder		STD
	Stomach or peptic ulcer		Stroke
	Thyroid Disease		Tuberculosis
	Urinary disorders		

List any history of cancer, date of diagnosis, treatments and years into remission, and name of oncologist: (E.g., breast cell cancer diagnosed in 2018 by Dr. XYZ, received chemo-radiation)

_____

_____

_____

_____

If you have been diagnosed with any previous rheumatologic condition, list the previous diagnosis, specify about the date of diagnosis, and current/past diagnosis, (e.g., Rheumatoid arthritis)

_____

_____

_____

_____

List the names of the medications for your rheumatologic medications and why you stopped taking it (e.g., Methotrexate- stopped because of ineffectiveness or developed headache)

_____

_____

_____

_____

PAST SURGICAL HISTORY – Please mark the surgeries that you have had.

	Colon removal surgery
	Ileostomy
	Right Knee Replacement surgery
	Left Knee Replacement surgery
	Right Shoulder Replacement surgery
	Left Shoulder Replacement surgery
	Spinal surgery
	Gastric bypass surgery
	Sinus surgery
	Nasal septum surgery
	Complete hysterectomy with cervix removed
	Partial hysterectomy without cervix removed
	Right Hip Replacement surgery
	Left Hip Replacement surgery
	Knee arthroscopic surgery
	Carpal Tunnel release surgery
	Mastectomy
	Lumpectomy
	C-section
	Coronary Bypass grafting
	Coronary stent placement
	Heart valve replacement surgery

Other surgeries:

_____

	Mother	Father	Sister	Brother	Grand father	Grand mother
Arthritis						
Rheumatoid Arthritis						
Cancer						
Diabetes						
Gout						
Heart Disease						
High blood pressure						
Kidney Disease						
Lupus						
Psoriasis/ Psoriatic arthritis						
Tuberculosis						
Osteoporosis						
Osteoarthritis						

Family History: Please check if your immediate family have a history of any condition below.

Other condition:

_____

Social History: Meaningful use of electronic medical records includes the collection of the following demographicinformation to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) □ Male □ Female

Marital Status: (select one) □ Single □ Married □ Divorced □ Widow □ Other:

_____

Number of Children: _____ Who do you live with?

_____

Race: (select one) □ Caucasian □ African American □ Asian □ Native American □ Native Alaskan □ NativeHawaiian □ Pacific Islander □ Declined

Ethnicity: (select one) □ Hispanic □ non-Hispanic □ Declined

Primary Language: (select one) □ English □ French □ Spanish □ Other:

_____

Occupation: _____

HEALTH HABITS

	Neves smoked
	Former smoker: year when you quit_____
	Currently daily smoker: Average number of cigarettes per day: _____
	Currently smoker on some days: average number of cigarettes per ***week:*** _____

If you are a past or current smoker, approximately how many years have you smoked? _____

Which products do you use? Check all that apply:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe Tobacco
- ☐ Others: _____

Do you use nicotine gum or nicotine patches? (Yes/No): _____

Do you drink alcohol? (Yes/No): _____

How many days per week do you drink? _____

How many drinks per day?_____

Please check all that apply:

- ☐ Beer
- ☐ Wine
- ☐ Hard liquor

☐ Other: _____

Illicit / Recreational Drug Use: Do you use drugs? (Yes/No) _____ How often? _____

If yes, please list:

_____

_____

********** IF NO JOINT PAIN, SKIP THIS SECTION **********

Pain began: (Years, months, weeks)

_____

Quality of Pain: Check all that apply

- ☐ Dull
- ☐ Burning
- ☐ Ache
- ☐ Sharp
- ☐ Throbbing
- ☐ Shooting
- ☐ Crushing

Pain Travels? (Yes/No) _____ If yes, travels to

_____

Pain Frequency:

- ☐ Constant

- ☐ Intermittent

Joint Swelling: (Yes/No) _____ If yes, what joint:

_____

What makes pain worse?

- ☐ Activity
- ☐ Food
- ☐ Stress
- ☐ Weather changes
- ☐ Humidity
- ☐ Others: _____

What makes pain better?

- ☐ Activity
- ☐ Medications
- ☐ Heat/massage
- ☐ Nothing
- ☐ Others: _____

Average level of pain in the past week? Mark on the line the AVERAGE level of your pain in the past week:

Answer: _____

Associated muscle weakness?

- ☐ All over

- ☐ Arms (Left, Right, Both): _____
- ☐ Legs (Left, Right, Both): _____
- ☐ Others: _____

List any associated symptoms with joint pain (e.g. Rash.,)

Mark areas of PAIN that you have on the diagram using SHADING.