

RHEUMATOLOGY MEDICAL HISTORY

I. Demographics

Name: _____ DOB: _____

SSN: _____ MRN: _____

Referring Physician: _____ Primary Care Physician: _____

Other Treating Physicians: _____

II. Presenting Problem(s)

Please explain what you are being seen for today: _____

III. Medical History

A. Medical Problems – Have you ever been diagnosed with any of the following?

Heart Disease

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Angina | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> Ischemic heart disease | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pericarditis |
| <input type="checkbox"/> Pericardial effusion | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Valvular Heart Disease (Mitral regurgitation, Mitral stenosis, Aortic insufficiency, Aortic stenosis) | | |
| <input type="checkbox"/> Other: _____ | | |

Lung Disease

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> COPD | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pulmonary fibrosis | <input type="checkbox"/> Interstitial lung disease | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Pleural effusion | <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Other: _____ | | |

Kidney Disease

- | | | |
|--|--|--|
| <input type="checkbox"/> Nephritis | <input type="checkbox"/> Renal insufficiency | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other: _____ | |

Liver Disease

- | | | |
|------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Other: _____ |
|------------------------------------|------------------------------------|---------------------------------------|

GI Disease

- | | | |
|---|--|---|
| <input type="checkbox"/> Reflux/Esophagitis | <input type="checkbox"/> GI bleed | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Diverticular disease | |
| <input type="checkbox"/> Gastric ulcer | <input type="checkbox"/> Duodenal ulcer | <input type="checkbox"/> Diverticulosis |
| | | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Gallbladder Disease (gall stones) | |
| <input type="checkbox"/> Other: _____ | | |

Edema

Cancer

- | | | |
|-------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Colon | <input type="checkbox"/> Breast | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Brain | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Pancreatic | <input type="checkbox"/> Ovarian | <input type="checkbox"/> Cervical |
| <input type="checkbox"/> Uterine | <input type="checkbox"/> Testicular | <input type="checkbox"/> Bone |
| <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Other: _____ |

Diabetes Type: _____

D. Serious Injuries - Please attach a separate sheet of paper if more room is necessary.

Please list any serious injuries especially musculoskeletal injuries, include approximate date:

E. Medications - Please attach a separate sheet of paper if more room is necessary.

Please list any prescription medication you are currently taking, include name, dose and frequency:

Please list any over the counter medication you are currently taking, include name, dose and frequency.

Please list any vitamins you are currently taking, include name, dose and frequency.

Please list any nutritional supplements you are currently using, include name, dose and frequency.

F. Allergies - Please attach a separate sheet of paper if more room is necessary.

Please list any **medications** you are allergic to and the type of reaction.

IV. Family History

Has any BLOOD relative ever been diagnosed with any of the following, please list relationship:

- Arthritic Disorder (please list type if known): _____
- Lupus: _____ Connective Tissue Disease: _____
- Gout: _____ Osteoporosis: _____
- Other: _____

V. Social History

Do you smoke? Yes No Packs per day _____ for _____ years. Type: Cigarettes Pipe

Do you use chewing tobacco? Yes No

Do you currently use alcohol? Yes No Type: Beer Wine Liquor

How many drinks _____ daily or _____ monthly or _____ yearly do you consume?

Do you use any illegal drugs? Yes No Type: _____

Do you exercise? Yes No Type: _____ Frequency: _____

VI. Review of Systems

Please indicate if you have had any trouble with the following over the past 5 years.

- Hair Loss (Alopecia)
 - Generalized
 - Thinning
 - Patchy
- Oral or Nasal Ulcers
- Rash: Type: _____ Area(s) of involvement: _____ When: _____
 - Photosensitivity (any rash with sun exposure)
 - Psoriasis
- Raynauds – Hands, fingers, feet or toes turn blue or white with cold exposure.
- Sicca Sx – severe dry eyes or dry mouth
- Low or abnormal blood count
 - Anemia
 - Low White Blood Count
 - Low Platelet Count
- Pleurisy or Pericarditis – inflammation of the lining of the lungs or heart
- Inflammatory Eye Disorder
 - Iritis
 - Uveitis
 - Conjunctivitis
- Hematuria or Proteinuria – history of blood or protein in urine
- Blood clot
 - Deep Venous Thrombosis
 - Pulmonary Embolism
- Gastrointestinal Symptoms
 - Abdominal Pain
 - Nausea
 - Vomiting
 - Diarrhea
 - GI bleeding
 - Colitis
 - Difficulty swallowing
- Neurological symptoms
 - Headaches
 - Visual symptoms
 - Numbness or tingling in extremities – Parasthesias
- Pain in jaw muscles while chewing – jaw claudication
- Sleep disturbance of any kind
- Fever (temperature elevation), chills, sweat
- Loss of appetite and/or unintentional weight loss
- Fatigue
- Respiratory Symptoms
 - Shortness of breath (dyspnea)
 - Cough – dry or productive
 - Coughing up blood
 - Chest pain worsened by breathing (pleuritic pain)
- Musculoskeletal Symptoms
 - Joint Pain
 - Joint Stiffness
 - Joint Swelling
 - Joint loss of motion
 - Back Pain
 - Muscle Pain
 - Muscle weakness
 - Nodules, lumps or bumps under the skin

**Women Only

Pregnancies:

Are you currently pregnant? Yes No _____ weeks

_____ Number of pregnancies

_____ Number of deliveries

_____ Number of miscarriages or abortions

Have you had any 2nd or 3rd trimester miscarriages? Yes No

Do you use birth control? Yes No

Do you plan to have anymore children? Yes No

Age of menopause (if applicable) _____