

RHEUMATOLOGY MEDICAL HISTORY

I. Demographics

Name: _____ Date: _____

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"/> Pleurisy | | |
| <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: _____
- Thyroid Disorder Type: _____
- Blood Disorder
- Anemia Low white count Low platelet count
- Other: _____
- Neurological or Muscular Disorder
- Stroke/TIA Seizures Migraine headaches
- Multiple Sclerosis Neuropathy Carpal Tunnel Syndrome
- Polymyositis Muscular Dystrophy Other: _____
- High Blood Pressure
- Elevated Cholesterol or Other Hyperlipidemia
- Blood Clot
- Deep Venous Thrombosis Pulmonary Embolism Other: _____
- Serious Infection(s)
- Pneumonia Endocarditis Tuberculosis
- Septicemia Pyelonephritis Abscess
- Other: _____
- Psychiatric Disorder
- Anxiety Depression Bipolar disorder
- Schizophrenia Other: _____
- Arthritis
- Degenerative Joint Disease Osteoarthritis Rheumatoid Arthritis
- Lupus Gout Pseudogout
- Connective Tissue Disease Spondyloarthopathy Ankylosing Spondylitis
- Scleroderma Sjogren's syndrome
- Polymyalgia Rheumatica (PMR) Other: _____
- Sexually Transmitted Disease:
- Gonorrhea Chlamydia Syphilis
- Other: _____
- Immune Deficiencies Type: _____

<input type="checkbox"/> Osteoporosis or Osteopenia If yes, when: _____	Have you ever had a bone density test? _____ Where: _____
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B. Surgeries – Please attach a separate sheet of paper if more room is necessary.

Please list any procedures you have had and the approximate date surgery was performed:

Please list any specific orthopaedic procedures you have had and the approximate date performed:

C. Other Hospitalizations – Please attach a separate sheet of paper if more room is necessary.

Please list any other hospitalizations, reason for hospitalization, approximate date and which hospital:

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): No Yes

Lupus: No Yes

Connective Tissue Disease: No Yes

Gout: No Yes

Osteoporosis: No Yes

Other: _____

V. Social History

Do you smoke? No Yes Former Smoker: Yes; Quit when: _____

Packs per day _____ for _____ years. Type: Cigarettes Pipe

Do you use chewing tobacco? No Yes

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

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

Have you ever used any illegal drugs? No Yes Type: _____

Do you exercise? No Yes

Type: _____ Frequency: _____

Do you have any tattoos? No Yes

VI. Review of Systems – Please indicate if you have had any trouble with the following over the past 5 years:

Hair Loss (Alopecia) No Yes If Yes: Generalized Thinning Patchy
Oral or Nasal Ulcers No Yes
Rash: No Yes
 Type: _____ Area(s) of involvement: _____ When: _____
Photosensitivity (any rash with sun exposure) No Yes Psoriasis: No Yes
Raynauds – Hands, fingers, feet or toes turn blue or white with cold exposure No Yes
Sicca Sx – severe dry eyes or dry mouth: No Yes
Low or abnormal blood count
 Anemia: No Yes Low White Blood Count: No Yes
 Low Platelet Count: No Yes
Pleurisy or Pericarditis (inflammation of the lining of the lungs or heart): No Yes
Inflammatory Eye Disorder
 Iritis: No Yes Uveitis: No Yes Conjunctivitis: No Yes
Hematuria or Proteinuria (history of blood or protein in urine): No Yes
Blood clot : No Yes
Gastrointestinal Symptoms
 Abdominal Pain: No Yes Nausea: No Yes Vomiting: No Yes
 Diarrhea: No Yes GI Bleeding: No Yes Colitis: No Yes
 Difficulty swallowing: No Yes
Neurological symptoms
 Headaches: No Yes Visual symptoms: No Yes
 Numbness or tingling in extremities (*parasthesias*): No Yes
 Cramping in jaw muscles while chewing (*jaw claudication*): No Yes
 Pain in jaw (*TMJ; Temporomandibular joint*) No Yes
 Difficulty sleeping: (*Sleep disturbance of any kind*) No Yes
 Fever (*temperature elevation*), chills, sweating: No Yes
 Loss of appetite: No Yes Unintentional weight loss: No Yes
 Fatigue: No Yes
Respiratory Symptoms
 Shortness of breath: No Yes Cough – dry or productive: No Yes
 Coughing up blood: No Yes Chest pain with breathing (pleuritic pain): No Yes
Musculoskeletal Symptoms
 Joint Pain: No Yes Joint Stiffness: No Yes Joint Swelling: No Yes
 Joint loss of motion: No Yes Back Pain: No Yes Muscle Pain: No Yes
 Muscle weakness: No Yes Nodules, lumps or bumps under the skin: No Yes

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) _____