

Patient History Form

Date: ___/___/_____

NAME: _____
Last Middle First

Birth date: ___/___/_____

Age: _____ Sex: F M

Who do we thank for referring you here: _____

Name of you Primary Care Physician: _____

What are your symptoms: _____

When did your symptoms start: _____

What makes your symptoms worse: _____

better: _____

Describe your pain in words (eg. Sharp, dull, burning, etc): _____

On a scale of 1 (no pain) to 10 (worst pain) how bad is your pain: _____

What medications/therapies have been tried so far: _____

Past Medical History: (check if "yes")

- | | | | | | |
|---|---|-------------------------------------|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bad headaches | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> DVT | <input type="checkbox"/> Depression | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Hypothyroid | |

Arthritis History:

- | | | | | |
|--|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus or "SLE" | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Childhood arthritis | <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sjogren's Syndrome | <input type="checkbox"/> Raynaud's |

Other Significant illnesses or unknown arthritis (please list): _____

Family Medical History: (check and give relationship)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Psoriasis _____ | <input type="checkbox"/> Osteoarthritis _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Lupus/SLE _____ |
| <input type="checkbox"/> Ankylosing spondylitis _____ | | | |

Patient's Name: _____ Date: _____ Physician initials: _____

Social History:

Do you smoke? Yes No Past - How long ago? _____

Do you drink caffeinated beverages? Yes No

Do you drink alcohol? Yes No Number per week _____

Do you exercise regularly? Yes No

Do you get enough sleep at night? Yes No

How many hours of sleep do you get nightly? _____

Do you wake up feeling rested? Yes No

Surgical History: (Please state Type, Year and Reason)

DRUG ALLERGIES: Yes No To what and what was the reaction? _____

Present Medications: (please include any over-the-counter, herbal supplements, alternative treatments)

Medication:	Dose:	How long:	Did it help:
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Past Arthritis Medications:

_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient's Name: _____ Date: _____ Physician initials: _____

Systems Review: (As you review the following, please check any of those problems which have significantly affected you)

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/"coffee grounds"
- Stomach pain relieved by food/milk
- Jaundice
- Worsening constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain/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? ___ / ___ / ____
- 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 months

Integumentary (skin ± breast)

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

Neurological system

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Numbness or tingling
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Agitation
- Depression
- 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

Date of last Bone Density (DXA scan): ___ / ___ / ____

Date of last Mammogram: ___ / ___ / ____

Patient's Name: _____ Date: _____ Physician initials: _____