



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:

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.

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: _____

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 No

Do 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 No

Do you wake up feeling rested? Yes No

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.)

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 _____

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 | |
| Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) | | <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 (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) </p> | | | | | |
| Pain Relievers | | | | | |
| 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"/> | |
| Disease Modifying Antirheumatic Drugs (DMARDs) | | | | | |
| 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"/> | |

Patient's Name _____ Date _____ Physician Initials _____
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PAST MEDICATIONS Continued

| Osteoporosis Medications | | | | | |
|---|--|--------------------------|--------------------------|--------------------------|--|
| 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"/> | |
| Gout Medications | | | | | |
| 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"/> | |
| Others | | | | | |
| 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:

Patient's Name _____ Date _____ Physician Initials _____

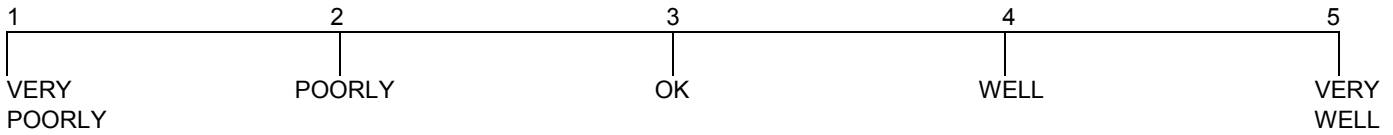
ACTIVITIES OF DAILY LIVING

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