PATIENT HISTORY FORM

Name ____ Date of Appointment __________________________________

Sex: F M Race: *(circle one)* African American Asian Caucasian Hispanic Other _________________________________

Date of Birth ____________________________ Age _____________ Birthplace ____

Marital Status _____________________ 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 Name of person making referral _____________________________

Primary Care Doctor:	Address:	Phone:
Referring Doctor:	Address:	Phone:
Orthopedic Surgeon:	Address:	Phone:
Other Doctor:	Address:	Phone:

Describe your present symptoms____

____

____

Date symptoms began (approximate) ___________________ 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 ____

____

RHEUMATIC (ARTHRITIS) HISTORY

YOURSELF		REALTIVE NAME / RELATIONSHIP	YOURSELF		RELATIVE NAME / RELATIONSHIP
	Ankylosing Spondylitis			Lupus or “SLE”	
	Arthritis (unknown type)			Osteoarthritis	
	Fibromyalgia			Osteoporosis	
	Gout			Rheumatoid Arthritis	
Other arthritis conditions					

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 _______________Date of last Colonoscopy _________________

Date of last Digital Rectal Exam ____________________

Patient’s Name ________________ Date ________________ Physician Initials ________________

THIS IS A CONFIDENTIAL RECORD: INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU HAVE AUTHORIZED TO DO SO.

PLEASE INDICATE WHICH OF THESE ARE CURRENT PROBLEMS:

	Yes	No
CONSTITUTIONAL		
Fatigue		
Fever		
Night Sweats		
EYES		
Blurred or Double Vision		
Dryness		
Loss of Vision		
Pain		
EARS-NOSE-THROAT-MOUTH		
Difficulty Swallowing		
Dry Mouth		
Loss of Hearing		
Ringing in Ears		
Sores in Mouth		
CARDIOVASCULAR		
Chest pain		
Heart Murmur		
High Blood Pressure		
Irregular Heart Beat		
Swollen Legs or Feet		
RESPIRATORY		
Cough		
Coughing up Blood		
Difficulty Breathing at Night		
Pain with Breathing		
Shortness of Breath		
Wheezing (Asthma)		

	Yes	No
GASTROINTESTINAL		
Black Stools		
Blood in Stools		
Constipation		
Heartburn		
Nausea		
Persistent Diarrhea		
Stomach Pain		
Vomiting		
GENITOURINARY		
Blood in Urine		
Difficult Urination		
Discharge from Penis / Vagina		
Getting up at night to Urinate		
Pain or Burning on Urination		
Ulcers		
Vaginal Dryness		
For Women Only:		
Age when Periods Began: ___________		
Were Your Periods Regular? ☐ Yes ☐ No		
Date of Last Period _______/_______/_______		
Date of Last Pap _______/_______/_______		
Bleeding after Menopause? ☐ Yes ☐ No		
Number of Pregnancies __________________		
Number of Miscarriages __________________		
MUSCULOSKELETAL		
Joint pain		
Joint swelling		
Muscle tenderness		
Back pain		
Neck pain		
Morning stiffness		
Lasting how long? _______Minutes _______ Hours		
List joints affected in the last six months:		

	Yes	No
INTEGUMENTARY (SKIN and/or BREAST)		
Bruising		
Color changes in hands or feet		
Hair Loss		
Hives		
Nodules / Bumps		
Rash		
Skin Tightness		
Sun Sensitive (sun allergy)		
NEUROLOGICAL SYSTEM		
Numb or Burning Hands or Feet		
Dizziness		
Headaches		
Memory Loss		
Muscle Spasm		
Seizures		
Weakness		
PSYCHIATRIC		
Anxiety		
Depression		
Easily Losing Temper		
Excessive worries		
ENDOCRINE		
Excessive Thirst		
Recent Weight Gain - Amount ________		
Recent Weight Loss - Amount ________		
HEMATOLOGIC / LYMPHATIC		
Anemia		
Bleeding Tendency		
Swollen Glands		
Tender Glands		
Transfusion / When		
ALLERGIC / IMMUNOLOGIC		
Frequent Sneezing		
Increased Susceptibility to Infection		

Patient's Name ____________________ **Date** ____________________ **Physician Initials** ____________________

THIS IS A CONFIDENTIAL RECORD: INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU HAVE AUTHORIZED TO DO SO.

Denver Arthritis Clinic

PAST MEDICAL HISTORY

Do you now or have you ever had:

	Yes	No		Yes	No	Previous Operations	Year	Reason
Blood Clots			Lung Disease			1.		
Cancer			Liver Disease					
Colitis / Crohns			Pericarditis			2.		
Depression			Pleurisy					
Diabetes			Psoriasis			3.		
Heart Disease			Psychiatric Illness					
Hepatitis			Raynaud's			4.		
High Blood Pressure			Seizure					
High Cholesterol			Stroke			5.		
HIV/AIDS			Tuberculosis					
Kidney Disease			Ulcers			6.		
Kidney Stones								

Have you broken any bones? ☐ Yes ☐ No

Describe:____

Any other serious injuries? ☐ Yes ☐ No

Describe:____

SOCIAL HISTORY

	Yes	No
Do you drink caffeinated beverages? Cups/glasses per day?_______________		
Do you drink alcohol? Number per week_______________		
Has anyone every told you to cut down on your drinking?		
Do you use drugs for reasons that are not medical?		
If yes, please list:		

	Yes	No
Do you smoke? Did you? How long ago? __________		
Do you exercise regularly? Type_______________ Amount per week_____________		
Do you get enough sleep at night?		
Do you wake up feeling rested?		
How many hours of sleep do you get at night?		

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings _____________ Number living _______________ Number deceased _______________

Number of children _____________ Number living _______________ Number deceased _______________

Health of children____

Do you know of any blood relative who has or had (check and give relationship)

☐ Alcoholism ____________ ☐ Colitis __________ ☐ Gout _______________ ☐ Lupus _____________ ☐ Tuberculosis__________

☐ Asthma _______________ ☐ Diabetes __________ ☐ Heart Disease__________ ☐ Psoriasis___________

☐ Bleeding Tendency _____ ☐ Epilepsy __________ ☐ High Blood Pressure_____ ☐ Rheumatoid Arthritis____________

☐ Cancer _______________ ☐ Fibromyalgia_______ ☐ Leukemia ____________ ☐ Thyroid Disease_______________

Patient's Name _______________ **Date** _______________ **Physician Initials** _______________

THIS IS A CONFIDENTIAL RECORD: INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU HAVE AUTHORIZED TO DO SO.

MEDICATIONS

Drug allergies ☐ Yes ☐ No To what? ______

Type of reaction ______

Any other allergies? ☐ Yes ☐ No Explain ______

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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

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/Dosages	Length of Time	Please check: Helped? A Lot	Some	Not at All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Ansaid (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); Advil/Motrin/Rufen (ibuprofen); Mobic (meloxicam); Naprosyn (naproxen); Oruvail (ketoprofen); Tolectin (tolmetin); Trilisate (choline magnesium trisalicylate); Vioxx (rofecoxib); Voltaren (diclofenac)					
PAIN MEDICATIONS					
Acetaminophen (Tylenol)		☐	☐	☐	
Hydrocodone/Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Oxycodone (Percocet/Percodan)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDS)					
Azathioprine (Imuran)		☐	☐	☐	
Cyclophosphamide (Cytoxan)					
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
BIOLOGIC AGENTS					
Abatacept (Orencia)		☐	☐	☐	
Adalimumab (Humira)		☐	☐	☐	
Anakinra (Kineret)		☐	☐	☐	
Certolizumab (Cimzia)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Golimumab (Simponi)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Rituximab (Rituxan)		☐	☐	☐	
Tocilizumab (Actemra)		☐	☐	☐	

Patient's Name ______ **Date** ______ **Physician Initials** ______

THIS IS A CONFIDENTIAL RECORD: INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU HAVE AUTHORIZED TO DO SO.

Drug names/Dosages	Length of Time	Please check: Helped? A Lot	Some	Not at All	Reactions
OSTEOPOROSIS MEDICATIONS					
Alendronate (Fosamax)		☐	☐	☐	
Calcitonin,injection or nasal (Forteo, Miacalcin, Calcimar)		☐	☐	☐	
Denosumab (Prolia)		☐	☐	☐	
Estrogen (Premarin, etc.)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Fluoride		☐	☐	☐	
Ibandronate (Boniva)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Zoledronate (Reclast)		☐	☐	☐	
GOUT MEDICATIONS					
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Colchicine		☐	☐	☐	
Febuxostat (Uloric)		☐	☐	☐	
Probenecid (Benemid)		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name **Date** **Physician Initials**