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*Board Certified Rheumatologist*

# PATIENT HISTORY FORM

Date of first appointment: _____

Name: _____ _____
FIRST LAST MIDDLE INITIAL MAIDEN

_____/_____/_____ Birth Sex: ❑ Female ❑ Male Birthplace: _____
Birthdate

Name of Primary Care Physician: _____

Referred by: _____

**Date symptoms began *(approximate)*: _____**

**Diagnosis:** _____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later):*

_____

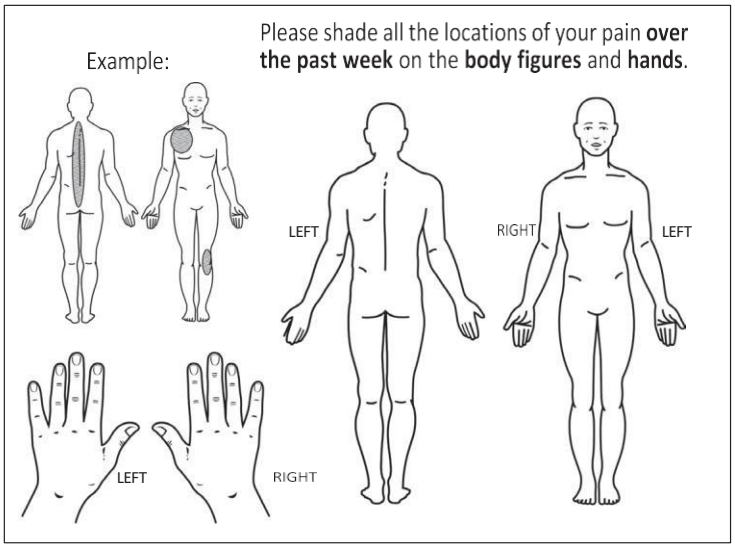
_____

_____

*Please list the names of other practitioners you have seen for this problem:*

_____

_____




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 |
|---|---|---|---|---|---|
| | Arthritis (unknown type) | | | Lupus or "SLE" | |
| | Osteoarthritis | | | Rheumatoid Arthritis | |
| | Gout | | | Ankylosing Spondylitis | |
| | Childhood Arthritis | | | Osteoporosis | |
| | Auto Immune Disease | | | Rheumatic Fever | |

Other arthritic conditions:_____

_____

46440 Benedict Drive, Suite 206, Sterling, VA 20164
703.988.4142 703.988.4147 FAX
www.nova-arthritis.com

## SOCIAL HISTORY

Are you currently: ❑ Employed ❑ Unemployed ❑ Disabled ❑ Retired – What year? _____

Occupation: _____ Employer: _____

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Never Married

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

Do you exercise regularly? ❑ Yes ❑ No Type: _____ Amount Per week: _____

## DIAGNOSTIC TESTS

**Date of last: Bone Density (DEXA)** _____ **Tuberculosis Blood Test (TB):** _____

**MRI Scan** _____ **CT Scan** _____ **Biopsy** _____

**Date of last mammogram** _____ **Date of last Eye Exam** _____ **Date of last Chest X-Ray**_____

## PAST MEDICAL HISTORY

Do you have or have you ever had: *(check if "Yes")*

- ❑ Anemia
- ❑ Asthma
- ❑ Bad Headaches
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Gastric/Ulcer
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Tuberculosis

**Other significant illness *(please list)*** _____

_____

Natural Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc. _____

_____

## PREVIOUS SURGERIES

| TYPE | YEAR | REASON |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

## 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 _____

## MEDICATIONS

**Drug allergies:** ❑No ❑Yes If yes, please list:_____

_____

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. | | | ❑ | ❑ | ❑ |
| 2. | | | ❑ | ❑ | ❑ |
| 3. | | | ❑ | ❑ | ❑ |
| 4. | | | ❑ | ❑ | ❑ |
| 5. | | | ❑ | ❑ | ❑ |
| 6. | | | ❑ | ❑ | ❑ |
| 7. | | | ❑ | ❑ | ❑ |
| 8. | | | ❑ | ❑ | ❑ |
| 9. | | | ❑ | ❑ | ❑ |
| 10. | | | ❑ | ❑ | ❑ |
| 11. | | | ❑ | ❑ | ❑ |
| 12. | | | ❑ | ❑ | ❑ |