



# 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")

| Yourselves               | Relative Name/Relationship | Yourselves               | 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: \_\_\_\_\_

What was your young adult max. height? \_\_\_\_\_

**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               |           |
| <b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| <p><b>Circle any you have taken in the past</b></p> <p>                     Ansaïd (flurbiprofen)    Arthrotec (diclofenac + misoprostil)    Aspirin (including coated aspirin)    Celebrex (celecoxib)    Clinoril (sulindac)<br/>                     Daypro (oxaprozin)    Disalcid (salsalate)    Dolobid (diflunisal)    Feldene (piroxicam)    Indocin (indomethacin)    Lodine (etodolac)<br/>                     Meclomen (meclofenamate)    Motrin/Rufen (ibuprofen)    Nalfon (fenoprofen)    Naprosyn (naproxen)    Oruvail (ketoprofen)<br/>                     Tolectin (tolmetin)    Trilisate (choline magnesium trisalicylate)    Vioxx (rofecoxib)    Voltaren (diclofenac)                 </p> |                |                          |                          |                          |           |
| <b>Pain Relievers</b>   |                |                          |                          |                          |           |
| 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"/> |           |
| <b>Disease Modifying Antirheumatic Drugs (DMARDS)</b>   |                |                          |                          |                          |           |
| 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"/> |           |
| Humira (Adalimumab)   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Cimzia (Certolizumab)   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Simponi (Golimumab)   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Orencia (Abatacept)   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Actemra (Tocilizumab)   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |
| Prosorba Column   |                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |           |

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

Physician Initials \_\_\_\_\_

**PAST MEDICATIONS Continued**

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

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Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

