

ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

NAME: _____

Today 's Date: _____

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Lupus or "SLE"	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Childhood arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Psoriasis/psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | <i>Uveitis/ Iritis</i> |

Other significant illnesses (please list): _____

Previous Operations

Type	Year	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Any previous fractures? No Yes Describe _____

Any other serious injuries? No Yes Describe _____

Do you smoke? Yes No In the past - How long ago? _____

Do you drink alcohol? No Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? Yes No

Do you use drugs for reasons that are not medical? No Yes If yes, please list: _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

Are you Applying for Disability? Yes No

Initial _____

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MEDICATIONS

Drug allergies: No Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug Dose (include strength and number of pills per day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

PERSONAL HISTORY

What is your highest educational level? High school Some college courses College graduate Advanced degree

What is your current or past occupation? _____

Are you currently working? : Yes No If yes, hours/week _____ If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

Initial _____

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SYSTEMS REVIEW

Date of last eye exam _____

Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: Never done Negative Positive

Date test performed: _____

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Morning stiffness
Lasting how long _____ Minutes
_____ Hours
- Joint pain
- Muscle weakness
- Joint swelling
- List joints affected in the last 6 months

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye

MOUTH

- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness
- Recent increase in tooth cavities

NOSE

- Nosebleeds
- Loss of smell

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw while chewing

NECK

- Swollen glands
- Tender glands

HEART AND LUNGS

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain relieved by food
- Vomiting of blood/"coffee grounds"
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

KIDNEY/URINE/BLADDER

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Frequent urination
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

BLOOD

- Anemia
- Bleeding tendency

SKIN

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive
- Skin tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling in hands/feet
- Memory loss
- Muscle weakness

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

No Yes If yes, at what age: _____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? Yes No

How many days apart? _____

Signature: _____

Date:- _____