



**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:    M F  
STREET APT#

\_\_\_\_\_ Telephone: Home:     
CITY STATE ZIP 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 work: \_\_\_\_\_

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: \_\_\_\_\_

Describe briefly 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:

\_\_\_\_\_

\_\_\_\_\_

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

Adapted from CLINHA0, 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: \_\_\_\_\_

\_\_\_\_\_ 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

**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:**

Age at Death	Age	IF LIVING		Health	IF DECEASED
			Cause		

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)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Leukemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter
<input type="checkbox"/> Colitis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Psoriasis	

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

**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.) \_\_\_\_\_

**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)                      Daypro (oxaprozin)      Disalcid (salsalate)      Dolobid (diflunisal)      Feldene (piroxicam)      Indocin (indomethacin)      Lodine (etodolac)                      Meclomen (meclofenamate)      MotrinRufen (ibuprofen)      Nalfon (fenoprofen)      Naprosyn (naproxen)      Oruvail (ketoprofen)                      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 ('laquenil)		<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"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		1:1	<input type="checkbox"/>	<input type="checkbox"/>	

**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"/>	0	
Raloxifene (Evista)		0	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	0	<input type="checkbox"/>	
Calcitonin injection or nasal (vliacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		CI	<input type="checkbox"/>	U	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	0	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gout Medications</b>					
Probenecid (Benamid)		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> _____
Colchicine		0	<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"/>	1:1	
<b>Others</b>					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	0	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	0	<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"/>	0	
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 \_\_\_\_\_



**ACTIVITIES OF DAILY LIVING**

<b>Are you able to:</b>	<b>Without Any Difficulty</b>	<b>With Some Difficulty</b>	<b>With Much Difficulty</b>	<b>Unable to Do</b>
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please mark the boxes beside any aids or assistive devices that you usually use for any of the above activities:**

- Cane  Crutches  Walker  Wheelchair  Built up or special utensils  Special or built up chair  
 Devices used for dressing (button hook, zipper pull, long handled shoe horn, etc.)  Other (please specify)-----

**Please mark the box beside any categories for which you usually need help from another person:**

- Dressing and grooming  Arising  Eating  Walking

**How much pain have you had because of your illness in the past week?** Place an X in the box that best describes the severity of your pain on a scale of 0-100.

0 100

No Pain ○○○○○○○○○○○○○○○○○○○○○○○○○○○○○○ Severe Pain

**How much pain have you had with your stomach (i.e., nausea, heartburn, bloating, pain, etc.) in the past week?**

Place an X in the box that best describes the severity of your stomach problems on a scale of 0-100.

0 100

No Stomach Problems ○○○○○○○○○○○○○○○○○○○○○○○○○○○○○○ Severe Stomach Problems

**How satisfied are you with your health now?**

- Very satisfied  Somewhat satisfied  **Neither** satisfied nor dissatisfied  Somewhat dissatisfied  Very dissatisfied

**Considering all the ways that your illness affects you, rate how you are doing on the following scale.**

Place an X in the box below that best describes how you are doing on a scale of 0-100.

0 100

Very Well ○○○○○○○○○○○○○○○○○○○○○○○○○○○○○○ Very Poorly

