



NW Rheumatology Associates, P.C.
Patient History

Date of first appointment \_\_\_/\_\_\_/\_\_\_

Form fields for patient information: Last Name, First, Middle, Birthdate, Birthplace, Address, Apt#, Age, Sex (Male/Female), Spouse's Name, City, State, Zip, Children's Names, Phone (Home/Work/Cell), Best number to contact you, and confidentiality consent.

Referred by [Check one]: Self, Family, Friend, Doctor, Other Health Professional

Name of Person making the referral

The name of the physician providing your general medical care:

Describe your symptoms briefly

Date symptoms began (Approximate)

Diagnosis given? [please list]

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

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

## MEDICAL HISTORY

Do you now or ever had: **[Check if "yes"]**

High blood pressure

Liver disease

Crohn's

Tuberculosis [TB]

Heart disease

Lung disease

Ulcerative Colitis

Positive TB skin test

Diabetes

Thyroid disease

Blood clots

Glaucoma

Stroke

Anxiety

Gout

Kidney disease

Depression

Uveitis/Iritis

Other significant illnesses [Please List]

### Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures?  No  Yes

If yes: What bone(s) did you fracture; and what were the circumstances and the age at which each fracture occurred. \_\_\_\_\_

## 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"/>
11.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.				<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>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Hydroxychloroquine (Plaquenil)					
Minocycline (Minocin)					
Sulfasalazine (Azulfidine)					
Methotrexate (Rheumatrex)					
Leflunomide (Arava)					
Azathioprine (Imuran)					
Mycophenolate (Cellcept)					
Gold pills (Auranofin, Ridaura)					
Gold shots (Miochrysine or Solganol)					
Penicillamine (Cuprimine)					
Quinacrine (Atabrine)					
Cyclosporine (Sandimmune or Neoral)					
Cyclophosphamide (Cytoxan)					
Anakinra (Kineret)					
Etanercept (Enbrel)					
Adalimumab (Humira)					
Infliximab (Remicade)					
Certolizumab (Cimzia)					
Golimumab (Simponi)					
Abatacept (Orencia)					
Rituximab (Rituxan)					
<b>Osteoporosis Medications</b>					
Estrogen (Premarin, etc)					
Etidronate (Didronel)					
Alendronate (Fosamax)					
Risedronate (Actonel)					
Ibandronate (Boniva)					
Zoledronic Acid (Reclast)					
Teriparatide (Forteo)					
Raloxifene (Evista)					
Calcitonin (Miacalin)					

Have you participated in any clinical trials for new medications?  Yes  No

If yes, list: \_\_\_\_\_  
 \_\_\_\_\_

## FAMILY HISTORY

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

Number of brothers \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

Number of sisters \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis (type unknown) _____ | <input type="checkbox"/> Osteoarthritis _____ | <input type="checkbox"/> Rheumatoid Arthritis _____   |
| <input type="checkbox"/> Gout _____                     | <input type="checkbox"/> Lupus _____          | <input type="checkbox"/> Ankylosing Spondylitis _____ |
| <input type="checkbox"/> Psoriasis _____                | <input type="checkbox"/> Crohn's _____        | <input type="checkbox"/> Ulcerative Colitis _____     |
| <input type="checkbox"/> Osteoporosis _____             | <input type="checkbox"/> Hip fracture _____   | <input type="checkbox"/> Spine fracture _____         |
| <input type="checkbox"/> Thyroid disease _____          | <input type="checkbox"/> Blood clots _____    |   |

## SOCIAL HISTORY

Never Married  Married  Divorced  Separated  Domestic Partner

Spouse:  Alive/age \_\_\_\_\_  Deceased/age \_\_\_\_\_ Major Illnesses \_\_\_\_\_

Do you smoke?  Yes  No  Past - # Cigarettes per day \_\_\_\_\_

Do you drink alcohol?  Yes  No  Past - # drinks per day \_\_\_\_\_

Do you use drugs for reasons that are not medical?  Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

List ages of each \_\_\_\_\_

Serious illnesses of children \_\_\_\_\_

\_\_\_\_\_

Occupation \_\_\_\_\_

Retired \_\_\_\_\_

## SYSTEMS REVIEW

Please mark either yes or no to all the questions.

### Constitutional

Yes  No ... Recent weight gain  
Amount \_\_\_\_\_

Yes  No ... Recent weight loss  
Amount \_\_\_\_\_

Yes  No ... Fatigue

Yes  No ... Weakness

Yes  No ... Night sweats

Yes  No ... Fever

### Eyes

Yes  No ... Pain

Yes  No ... Redness

Yes  No ... Loss of Vision

Yes  No ... Double or blurred vision

Yes  No ... Dryness

Yes  No ... Feels like something in eye

### Ears-Nose-Mouth-Throat

Yes  No ... Loss of hearing

Yes  No ... Nosebleeds

Yes  No ... Loss of smell

Yes  No ... Dryness in nose

Yes  No ... Sores in mouth

Yes  No ... Loss of taste

Yes  No ... Dryness of mouth

Yes  No ... Hoarseness

### Cardiovascular

Yes  No ... Pain in chest

Yes  No ... Irregular heart beat

Yes  No ... High blood pressure

Yes  No ... Swollen legs or feet

### Respiratory

Yes  No ... Shortness of breath

Yes  No ... Difficulty in breathing at night

Yes  No ... Cough

Yes  No ... Coughing of blood

Yes  No ... wheezing

### Gastrointestinal

Yes  No ... Loss of appetite

Yes  No ... Nausea

Yes  No ... Vomiting of blood or  
coffee ground material

Yes  No ... Heartburn

Yes  No ... Difficulty Swallowing

Yes  No ... Abdominal pain

Yes  No ... Diarrhea

Yes  No ... Constipation

Yes  No ... Blood in stools

Yes  No ... Black stools

### Genitourinary

Yes  No ... Difficult urination

Yes  No ... Pain or burning on urination

Yes  No ... Blood in urine

Yes  No ... Discharge from penis/vagina

Yes  No ... Vaginal dryness

Yes  No ... Rash/ulcers

### For Women Only:

Age when periods began: \_\_\_\_\_

Yes  No ... Periods regular

How many days apart? \_\_\_\_\_

Date of last period? \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last pap? \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of pregnancies? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_

### Musculoskeletal

Yes  No ... Morning stiffness

Lasting how long?

\_\_\_\_\_ Minutes \_\_\_\_\_ Hours

Yes  No ... Joint pain

Yes  No ... Muscle weakness

Yes  No ... Muscle tenderness

Yes  No ... Joint swelling

List Joints affected in the last 6 mos.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Integumentary (skin and/or breast)

Yes  No ... Easy bruising

Yes  No ... Rash

Yes  No ... Sun sensitive

Yes  No ... Tightness

Yes  No ... Nodules/bumps

Yes  No ... Hair loss

Yes  No ... Color changes of  
hands or feet in the cold

### Neurological System

Yes  No ... Headaches

Yes  No ... Dizziness

Yes  No ... Memory loss

### Psychiatric

Yes  No ... Excessive worries

Yes  No ... Anxiety

Yes  No ... Easily losing temper

Yes  No ... Depression

Yes  No ... Agitation

Yes  No ... Difficulty falling asleep

Yes  No ... Difficulty staying asleep

### Endocrine

Yes  No ... Excessive thirst

### Hematologic/Lymphatic

Yes  No ... Swollen glands

Yes  No ... Tender glands

Yes  No ... Anemia

Yes  No ... Bleeding tendency

Yes  No ... Transfusions/when \_\_\_\_\_

### Allergic/Immunologic

Yes  No ... Hayfever/asthma

Yes  No ... Increased susceptibility  
to infection

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## HOME CONDITIONS

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Check one:  House  Apartment

Do you have stairs to climb?  Yes  No If yes, how many? \_\_\_\_\_

Number of people in household \_\_\_\_\_ Relationship, and age of each? \_\_\_\_\_

Who does most of the housework? \_\_\_\_\_

Who does most of the shopping? \_\_\_\_\_

What is the hardest thing for you to do? \_\_\_\_\_

On the scale below, circle a number which best describes your situation: ***Most of the time, I function...***

