

Name: _____ Birthdate: _____ / _____ / _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

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: _____

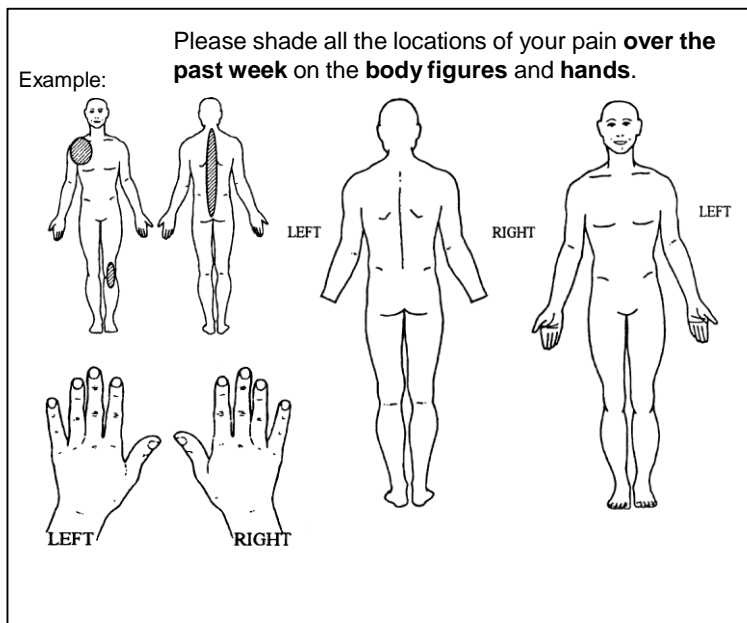
Describe briefly your present symptoms: _____

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:



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 HISTORY

ACTIVITIES OF DAILY LIVING

Because of health problems, do you have difficulty: (Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the hardest thing for you to do? _____

Are you applying for disability?..... Yes No

Are you receiving disability?..... Yes No

➔ If yes, for what diagnosis(es)? _____

Do you have a medically related lawsuit pending?..... Yes No

MEDICATIONS

Drug allergies: No Yes → What drug and 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 SURGICAL HISTORY

Year	Procedure

SOCIAL HISTORY

Do you smoke? ____ Yes ____ No If yes, how many a day? _____ For how many years? _____
 Do you drink alcohol? ____ Yes ____ No If yes, how many a day? _____ For how many years? _____

Occupation(s): _____

FAMILY HISTORY (only list those with illness)

	Gout	Psoriasis	RA	Lupus	Cancer (type)	Heart Disease
Father						
Mother						
Grandparent						
Grandparent						
Siblings						
Siblings						
Children						