GULF COAST RHEUMATOLOGY

Patient History Form

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:

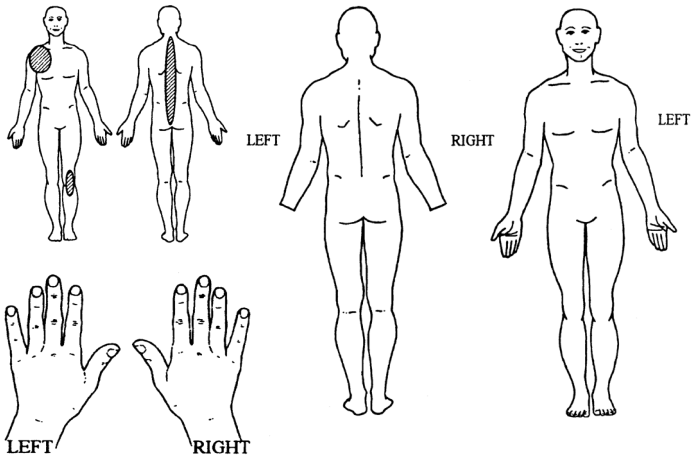
_____

_____

_____

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

Example:



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.)	☐	☐	☐
Dressing yourself?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐

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 & number of pills per day	What do you take this medication for?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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 - MGM						
Grandparent - MGF						
Grandparent - PGM						
Grandparent - PGF						
Siblings						
Siblings						