Joint Endeavors

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

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

Address: _____ (STREET / APT. #) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____

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 week _____

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: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

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

_____

_____

_____

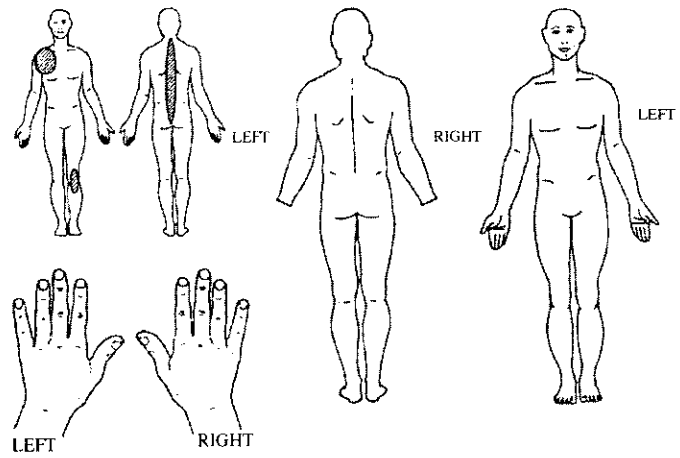
Please list the names of other practitioners you have seen for this problem:

_____

_____

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 (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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

PLEASE TURN OVER

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

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_____ /_____/_____

Constitutional
- ❑ Recent weight gain
  amount_____
- ❑ Recent weight loss
  amount_____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears - Nose - Mouth - Throat
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

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

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period?_____/_____ /_____

Date of last pap?_____ /_____ /_____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies?_____

Number of miscarriages?_____

Musculoskeletal
- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules / bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric
- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine
- ❑ Excessive thirst

Hematologic / Lymphatic
- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion / when _____

Allergic / Immunologic
- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

Joint Endeavors

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

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.)

_____

_____

_____

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:

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

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)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

PLEASE TURN OVER

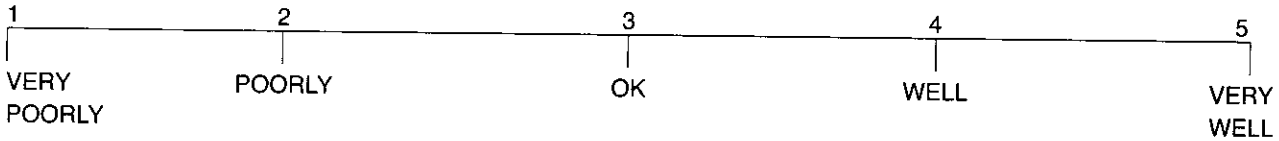
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

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



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.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, a walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do? _____

Are you receiving disability?	❑ Yes	❑ No
Are you applying for disability?	❑ Yes	❑ No
Do you have a medically related lawsuit pending?	❑ Yes	❑ No

Patient's Name _____ Date _____ Physician Initials _____

Joint Endeavors

MEDICATIONS

Drug allergies: No Yes If yes, list medication(s) and type of reaction: _____

_____

_____

_____

Present medications (List any medications you are taking, including over the counter items.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Past Medications: Please review this list of "arthritis" medications and circle any you were on in the past.

NSAIDs:

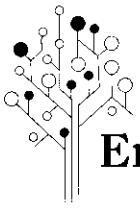
Ansaid (flurbiprofen)	Arthrotec (diclofenac/misoprostol)	Aspirin
Celebrex (celecoxib)	Clinoril (sulindac)	Daypro (oxaprozin)
Disalcid (salsalate)	Dolobid (diflunisal)	Feldene (piroxicam)
Indocin (indomethacin)	Lodine (etodolac)	Mobic (meloxicam)
Motrin / Advil (ibuprofen)	Nalfon (fenoprofen)	Naprosyn / Vimovo / Aleve (naproxen)
Oruvail (ketoprofen)	Relafen (nabumetone)	Tolectin (tolmetin)
Vioxx (rofecoxib)	Voltaren (diclofenac)	Other: _____

Other pain relievers: acetaminophen codeine hydrocodone oxycodone tramadol

DMARDs: gold hydroxychloroquine (Plaquenil) methotrexate sulfasalazine (Azulfidine) leflunomide (Arava) cyclosporine cyclophosphamide (Cytoxan) Enbrel Humira Actemra Cimzia Actemra Kineret Orencia Remicade Rituxan Xeljanz Otezla Stelara Cosentyx

Osteoporosis: estrogen raloxifene (Evista) alendronate (Fosamax) risedronate (Actonel) ibandronic acid (Boniva) zoledronic acid (Reclast) Prolia Forteo

Gout: probenecid allopurinol colchicine Krystexxa Uloric Zurampic



Joint Endeavors

Patient Information: (please print neatly)

Full Name: _____

Mailing Address: _____

City, State: _____ Zip Code: _____

Social Security Number: _____ Birthdate: _____

Phone Number: Home _____ Work _____ Cell _____

E-mail: _____

Marital Status (circle one): Married Single Divorced Widowed Separated

Race (circle one): African-American Asian-American Caucasian Native American Hispanic/Latino
Multiracial Other Decline to specify

Place of Employment: _____

Referring Provider: _____ Primary Care Provider: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Approximately when did you last see your primary care provider? _____

Emergency Contact Name, Relationship to You and Phone Number:

_____

Insured Party Information

What is your primary insurance company and ID #? _____

_____

What is your secondary insurance company and ID #? _____

_____

If insured party's information is different from patient information above, please complete the following:

Insured's Full Name: _____ Insured's Birthdate: _____

Insured's Employer: _____

Insured's Age: _____ Insured's Social Security Number: _____

Insured's Contact Numbers: Home _____ Work _____ Cell _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable directly to me to the physician.

I authorize Joint Endeavors PLLC to charge my account $50 if I fail to show for a follow-up appointment or cancel it without at least 24 hours notice. I authorize Joint Endeavors PLLC to charge my account $200 if I fail to keep a new patient appointment or cancel it without at least 24 hours notice.

By signing below, I certify that I have read, understand and agree with the office's policies as stated above.

➢ _____ _____

Signature of patient or parent if patient is a minor Date

Joint Endeavors

145 Chenoweth Lane • Louisville, KY 40207 • (502) 890-3899

For our new patients:

We are located at 145 Chenoweth Lane, Louisville, KY 40207.

Our parking lot is located behind the building, and can be accessed by turning right onto Kennison if coming from Shelbyville Road and left onto Kennison if coming from Brownsboro Road. You will then take a quick left into our parking lot. Look for the Joint Endeavors parking signs.

For patients with significant mobility issues, we have a ground floor exam room with a handicapped parking spot right at the door. If you need this easy access room, please let us know when scheduling so we may reserve it for you.

Please bring your insurance card(s), a list of your medications, your pharmacy's phone number, a photo ID and any pertinent records with you to your visit.

Phone: 502 890-3899

PARKING –

TURN ON KENNISON AVENUE AND DRIVE BEHIND BRUNDAGE JEWELERS TO GET TO OUR PARKING LOT.