

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 _____

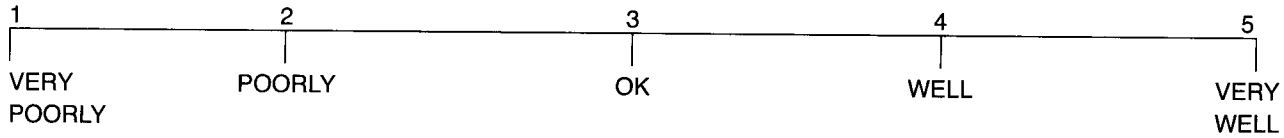
ACTIVITIES OF DAILY LIVING

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<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"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, a walker or a wheelchair? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the hardest thing for you to do? _____			
Are you receiving disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you applying for disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a medically related lawsuit pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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")

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bad headaches | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> 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)

- | | | | |
|---|--|--|---|
| <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 _____

PLEASE TURN OVER



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