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**

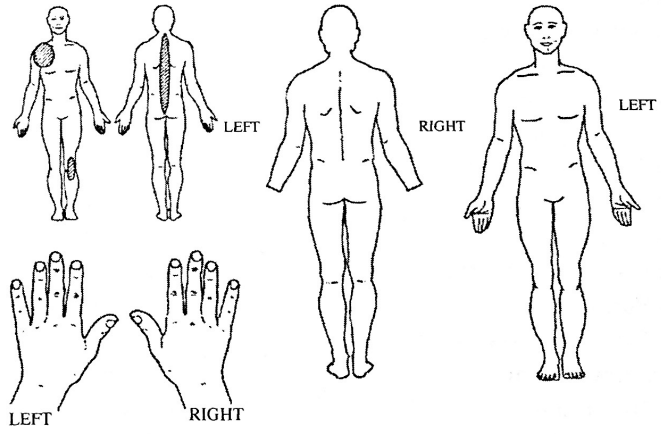
Diagnosis: _____

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 _____

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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

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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 _____	

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PLEASE TURN OVER

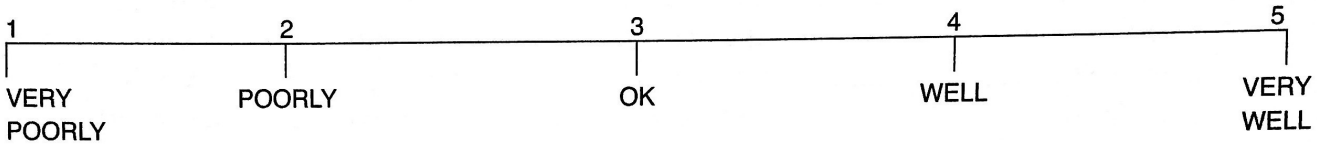
ACTIVITIES OF DAILY LIVING

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

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