ALLERGY ASTHMA
IMMUNOLOGY OF ROCHESTER PC

Rheumatology Form

Patient Personal History

Patients Name _____ Date _____ Physician Initials _____

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

Name: _____ Birthdate: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ❑ F ❑ M
STREET APT#

_____ Telephone: Home (____) _____
CITY STATE ZIP

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): _____

Diagnosis: _____

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

_____

_____

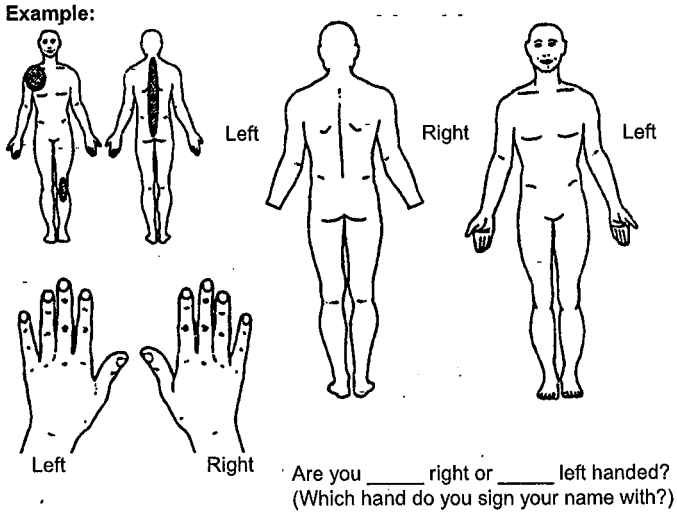
_____

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:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

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 Name: _____ Date: _____ Physician Initials _____

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 breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting 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
- ❑ Vagina 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 Name: _____ Date: _____ Physician Initials _____

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 (chiropracty, magnets, massage, over-the-counter preparations, etc.)
_____
_____
_____

Previous Operations

Type	*Year*	*Reason*
1,		
2'		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Descibe _____
Any other serious injuries? ❑ No ❑ Yes Descibe _____

FAMILY HISTORY:

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

Number of siblings _____ Number Living _____ Number deceased _____
Number of children _____ Number of 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 _____	❑ Tubeerculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient Name: _____ Date: _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of 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(nclude strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1,			❑	❑	❑
2'			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: A Lot	Some	Helped? Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past					
Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib)					
Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (proxicam)					
Indocin (indomethacin) Lodine (etodoiac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen)					
Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate)					
Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers		❑	❑	❑	
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	

Patient Name: _____ Date: _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin,		❑	❑	❑	
Calcimar)		❑	❑	❑	
Residronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

Your Occupation: _____ Are you currently working? ❑Yes ❑No

If not, are you ❑retired ❑disabled ❑sick leave? Do you receive disability or SSI? ❑Yes ❑No

If yes, for what disability? _____ What date did this disability begin? _____

Occupation and Activities

Check one: ❑House ❑Apartment Do you have stairs to climb? ❑Yes ❑No If yes, how many? _____

Number of people in household _____ Who does most of the shopping? _____

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

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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?			

continued

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

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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

	Usually	Sometimes	No
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with other 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 item)			

What is the hardest thing for you to do? _____

Are you applying for disability? Yes _____ No _____

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

NOTES