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)

_____

_____

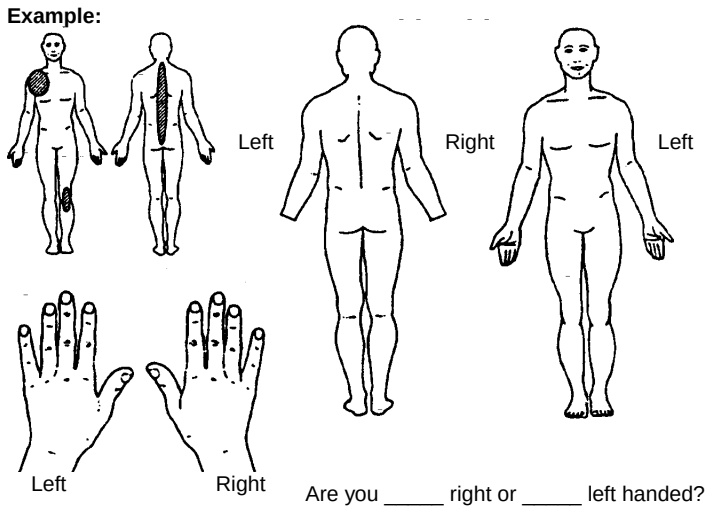
_____

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 chldren _____ 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: Helped? A Lot	Some	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