RAMOS RHEUMATOLOGY, PC

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____

Last First M. I.

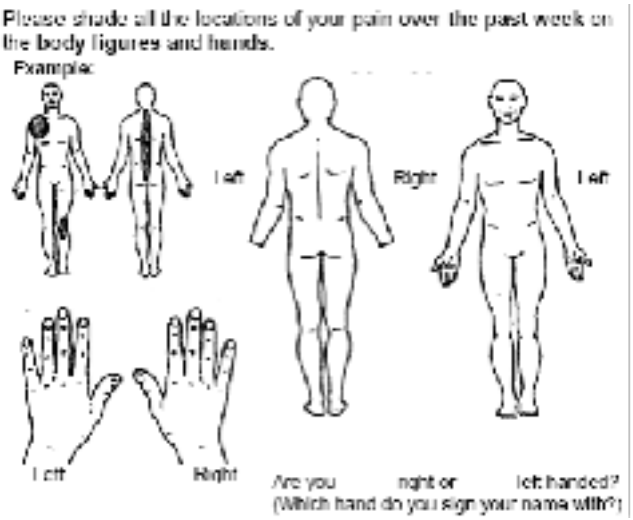
Age:_____ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____



When did your symptoms start? _____

What diagnosis have you been given, if any?

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

Physician initials _____

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

Physician initials _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	
Osteoarthritis	❑	❑	→	
Rheumatoid arthritis	❑	❑	→	
Gout	❑	❑	→	
Lupus or "SLE"	❑	❑	→	
Ankylosing spondylitis	❑	❑	→	
Childhood arthritis	❑	❑	→	
Sjogren's syndrome	❑	❑	→	
Osteoporosis	❑	❑	→	
Psoriasis/psoriatic arthritis	❑	❑	→	

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Other significant illnesses (please list): _____

_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		

Physician initials _____

5. _____ _____ _____
6. _____ _____ _____
7. _____ _____ _____

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Physician initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _____ 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? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age at death	Cause
Father				

Physician initials _____

Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

Physician initials _____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

GENERAL

❑ Recent weight gain; how much____

❑ Recent weight loss: how much____

❑ Fatigue

❑ Weakness

❑ Fever

❑ Night sweats

MUSCLE/JOINTS/BONES

❑ Morning stiffness

Lasting how long ____ Minutes

____ Hours

❑ Joint pain

❑ Muscle weakness

❑ Joint swelling

List joints affected in the last 6 months

_____

_____

_____

_____

EARS

❑ Ringing in ears

❑ Loss of hearing

EYES

❑ Pain

❑ Redness

❑ Loss of vision

❑ Double or blurred vision

THROAT

❑ Frequent sore throats

❑ Hoarseness

❑ Difficulty in swallowing

❑ Pain in jaw while chewing

NECK

❑ Swollen glands

❑ Tender glands

HEART AND LUNGS

❑ Pain in chest

❑ Irregular heart beat

❑ Sudden changes in heart beat

❑ Shortness of breath

❑ Difficulty in breathing at night

❑ Swollen legs or feet

❑ Cough

❑ Coughing of blood

❑ Wheezing

STOMACH AND INTESTINES

❑ Nausea

❑ Heartburn

❑ Stomach pain relieved by food

❑ Vomiting of blood/"coffee grounds"

❑ Yellow jaundice

❑ Increasing constipation

❑ Persistent diarrhea

❑ Blood in stools

❑ Black stools

BLOOD

❑ Anemia

❑ Bleeding tendency

SKIN

❑ Easy bruising

❑ Redness

❑ Rash

❑ Hives

❑ Sun sensitive

❑ Skin tightness

❑ Nodules/bumps

❑ Hair loss

❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM

❑ Headaches

❑ Dizziness

❑ Fainting or loss of consciousness

❑ Numbness or tingling in hands/feet

❑ Memory loss

❑ Muscle weakness

PSYCHIATRIC

❑ Depression

❑ Excessive worries

❑ Difficulty falling asleep

❑ Difficulty staying asleep

Physician initials _____

❑ Dryness

❑ Feels like something in eye

MOUTH

❑ Sore tongue

❑ Bleeding gums

❑ Sores in mouth

❑Loss of taste

❑ Dryness

❑ Recent increase in tooth cavities

NOSE

❑ Nosebleeds

❑ Loss of smell

KIDNEY/URINE/BLADDER

❑ Difficult urination

❑ Pain or burning on urination

❑ Blood in urine

❑ Cloudy, “smoky” urine

❑ Pus in urine

❑ Discharge from penis/vagina

❑ Frequent urination

❑ Getting up at night to pass urine

❑ Vaginal dryness

❑ Rash/ulcers

❑ Sexual difficulties

❑ Prostate trouble

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

❑ No ❑ Yes If yes, at what age: ____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ❑ Yes ❑ No

How many days apart? _____

Physician initials _____

CORRONA modified HEALTH ASSESSMENT (mHAQ)
PATIENT QUESTIONNAIRE

PAGE 1 of 1 Site ID _____

Patient ID _____ - _____ - _____ Date _____

Please mark the one response which best describes your usual abilities over the past few days:

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
1.) Dress yourself, including tying shoelaces and doing buttons?				
2.) Get in and out of bed?				
3.) Lift a full cup or glass to your mouth?				
4.) Walk outdoors on flat ground?				
5.) Wash and dry your entire body?				
6.) Bend down and pick up clothing from the floor?				
7.) Turn regular faucets on and off?				
8.) Get in and out of the car?				

SUBJECT ASSESSMENT OF PAIN & DISEASE ACTIVITY

PAIN: How much pain have you had because of your arthritis? Put a mark on the scale (like this |) to show how severe your pain has been.

NO PAIN _____ PAIN AS BAD AS IT COULD BE
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

DISEASE ACTIVITY: Considering all the ways arthritis affects you, put a mark on the scale (like this |) to show how well you are doing.

VERY WELL _____ VERY POORLY
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

SKIN DISEASE ACTIVITY (Psoriasis Patients Only) Put a mark on the scale (like this |) to show the activity of your SKIN DISEASE ONLY.

VERY WELL _____ VERY POORLY
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100