

## RHEUMATOLOGY MEDICAL HISTORY

### I. Demographics

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ MRN: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Other Treating Physicians: \_\_\_\_\_

---

### II. Presenting Problem(s)

Please explain what you are being seen for today: \_\_\_\_\_

\_\_\_\_\_

---

### III. Medical History

#### A. Medical Problems – Have you ever been diagnosed with any of the following?

Heart Disease

Heart Attack (MI)

Congestive Heart Failure

Arrhythmia

Atrial fibrillation

Angina

Coronary artery disease

Ischemic heart disease

Cardiomyopathy

Pericarditis

Pericardial effusion

Rheumatic fever

Heart murmur

Valvular Heart Disease (Mitral regurgitation, Mitral stenosis, Aortic insufficiency, Aortic stenosis)

Other: \_\_\_\_\_

Lung Disease

Emphysema

COPD

Asthma

Pulmonary fibrosis

Interstitial lung disease

Sleep apnea

Pleural effusion

Pulmonary hypertension

Sarcoidosis

Pleurisy

Other: \_\_\_\_\_

Kidney Disease

Nephritis

Renal insufficiency

Renal failure

Kidney stones

Other: \_\_\_\_\_

Liver Disease

Hepatitis

Cirrhosis

Other: \_\_\_\_\_

GI Disease

Reflux/Esophagitis

GI bleed

Irritable Bowel Syndrome

Ulcer Disease

Diverticular disease

Gastric ulcer

Duodenal ulcer

Diverticulosis

Diverticulitis

Colitis

Gallbladder Disease (gall stones)

Other: \_\_\_\_\_

Edema

Cancer

Colon

Breast

Lung

Stomach

Brain

Prostate

Pancreatic

Ovarian

Cervical

Uterine

Testicular

Bone

Lymphoma

Leukemia

Other: \_\_\_\_\_

- Diabetes Type: \_\_\_\_\_  
 Thyroid Disorder Type: \_\_\_\_\_  
 Blood Disorder  
 Anemia  Low white count  Low platelet count  
 Other: \_\_\_\_\_  
 Neurological or Muscular Disorder  
 Stroke/TIA  Seizures  Migraine headaches  
 Multiple Sclerosis  Neuropathy  Carpal Tunnel Syndrome  
 Polymyositis  Muscular Dystrophy  Other: \_\_\_\_\_  
 High Blood Pressure  
 Elevated Cholesterol or Other Hyperlipidemia  
 Blood Clot  
 Deep Venous Thrombosis  Pulmonary Embolism  Other: \_\_\_\_\_  
 Serious Infection(s)  
 Pneumonia  Endocarditis  Tuberculosis  
 Septicemia  Pyelonephritis  Abscess  
 Other: \_\_\_\_\_  
 Psychiatric Disorder  
 Anxiety  Depression  Bipolar disorder  
 Schizophrenia  Other: \_\_\_\_\_  
 Arthritis  
 Degenerative Joint Disease  Osteoarthritis  Rheumatoid Arthritis  
 Lupus  Gout  Pseudogout  
 Connective Tissue Disease  Spondyloarthopathy  Ankylosing Spondylitis  
 Scleroderma  Sjogren's syndrome  
 Polymyalgia Rheumatica (PMR)  Other: \_\_\_\_\_  
 Sexually Transmitted Disease:  
 Gonorrhea  Chlamydia  Syphilis  
 Other: \_\_\_\_\_  
 Immune Deficiencies Type: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Osteoporosis or Osteopenia<br>If yes, when: _____ | Have you ever had a bone density test? _____<br>Where: _____ |
|--|--|

**B. Surgeries** – Please attach a separate sheet of paper if more room is necessary.

Please list any procedures you have had and the approximate date surgery was performed:

\_\_\_\_\_

Please list any specific orthopaedic procedures you have had and the approximate date performed:

\_\_\_\_\_

\_\_\_\_\_

**C. Other Hospitalizations** – Please attach a separate sheet of paper if more room is necessary.

Please list any other hospitalizations, reason for hospitalization, approximate date and which hospital:

\_\_\_\_\_

\_\_\_\_\_

**D. Serious Injuries** – Please attach a separate sheet of paper if more room is necessary.

Please list any serious injuries especially musculoskeletal injuries, include approximate date:

---

**E. Medications** – Please attach a separate sheet of paper if more room is necessary.

Please list any prescription medication you are currently taking, include name, dose and frequency:

---

---

Please list any over the counter medication you are currently taking, include name, dose and frequency:

---

---

Please list any vitamins you are currently taking, include name, dose and frequency:

---

---

Please list any nutritional supplements you are currently using, include name, dose and frequency:

---

---

**F. Allergies** – Please attach a separate sheet of paper if more room is necessary.

Please list any **medications** you are allergic to and the type of reaction:

---

---

---

#### IV. Family History

Has any BLOOD relative ever been diagnosed with any of the following, please list relationship:

Arthritic Disorder (please list type if known):  No  Yes

Lupus:  No  Yes

Connective Tissue Disease:  No  Yes

Gout:  No  Yes

Osteoporosis:  No  Yes

Other: \_\_\_\_\_

---

#### V. Social History

Do you smoke?  No  Yes Former Smoker:  Yes; Quit when: \_\_\_\_\_

Packs per day \_\_\_\_\_ for \_\_\_\_\_ years. Type:  Cigarettes  Pipe

Do you use chewing tobacco?  No  Yes

Do you currently use alcohol?  No  Yes Type:  Beer  Wine  Liquor

How many drinks \_\_\_\_\_ daily or \_\_\_\_\_ monthly or \_\_\_\_\_ yearly do you consume?

Have you ever used any illegal drugs?  No  Yes Type: \_\_\_\_\_

Do you exercise?  No  Yes

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Do you have any tattoos?  No  Yes

---

**VI. Review of Systems** – Please indicate if you have had any trouble with the following over the past 5 years:

Hair Loss (Alopecia)       No    Yes      If Yes:    Generalized       Thinning       Patchy  
Oral or Nasal Ulcers       No    Yes  
Rash:       No    Yes  
    Type: \_\_\_\_\_ Area(s) of involvement: \_\_\_\_\_ When: \_\_\_\_\_  
Photosensitivity (any rash with sun exposure)       No    Yes      Psoriasis:       No    Yes  
Raynauds – Hands, fingers, feet or toes turn blue or white with cold exposure       No    Yes  
Sicca Sx – severe dry eyes or dry mouth:       No    Yes  
Low or abnormal blood count  
    Anemia:       No    Yes      Low White Blood Count:       No    Yes  
    Low Platelet Count:       No    Yes  
Pleurisy or Pericarditis (inflammation of the lining of the lungs or heart):       No    Yes  
Inflammatory Eye Disorder  
    Iritis:       No    Yes      Uveitis:       No    Yes      Conjunctivitis:       No    Yes  
Hematuria or Proteinuria (history of blood or protein in urine):       No    Yes  
Blood clot :       No    Yes  
Gastrointestinal Symptoms  
    Abdominal Pain:       No    Yes      Nausea:       No    Yes      Vomiting:       No    Yes  
    Diarrhea:       No    Yes      GI Bleeding:       No    Yes      Colitis:       No    Yes  
    Difficulty swallowing:  No    Yes  
Neurological symptoms  
    Headaches:       No    Yes      Visual symptoms:       No    Yes  
    Numbness or tingling in extremities (*parasthesias*):       No    Yes  
    Cramping in jaw muscles while chewing (*jaw claudication*):       No    Yes  
    Pain in jaw (*TMJ; Temporomandibular joint*)       No    Yes  
    Difficulty sleeping: (*Sleep disturbance of any kind*)       No    Yes  
    Fever (*temperature elevation*), chills, sweating:       No    Yes  
    Loss of appetite:       No    Yes      Unintentional weight loss:       No    Yes  
    Fatigue:       No    Yes  
Respiratory Symptoms  
    Shortness of breath:       No    Yes      Cough – dry or productive:       No    Yes  
    Coughing up blood:       No    Yes      Chest pain with breathing (pleuritic pain):       No    Yes  
Musculoskeletal Symptoms  
    Joint Pain:       No    Yes      Joint Stiffness:       No    Yes      Joint Swelling:       No    Yes  
    Joint loss of motion:       No    Yes      Back Pain:       No    Yes      Muscle Pain:       No    Yes  
    Muscle weakness:       No    Yes      Nodules, lumps or bumps under the skin:       No    Yes

**\*Women Only\***

Pregnancies: Are you currently pregnant?    Yes    No   \_\_\_\_\_ weeks  
    \_\_\_\_\_ Number of pregnancies  
    \_\_\_\_\_ Number of deliveries  
    \_\_\_\_\_ Number of miscarriages or abortions  
Have you had any 2<sup>nd</sup> or 3<sup>rd</sup> trimester miscarriages?       Yes    No  
Do you use birth control?       Yes    No  
Do you plan to have anymore children?       Yes    No  
Age of menopause (if applicable) \_\_\_\_\_