INITIAL CONSULTATION – MEDICAL HISTORY

Name: ______________________ **Date of Birth:** ______________ **Date:** ________________

Referring Physician: ___________________ **PCP Name:** ______________________________

Send letter: □Yes □No

When did your symptoms start? (Approximate date): ___________________________________

Reason for today's visit:

____

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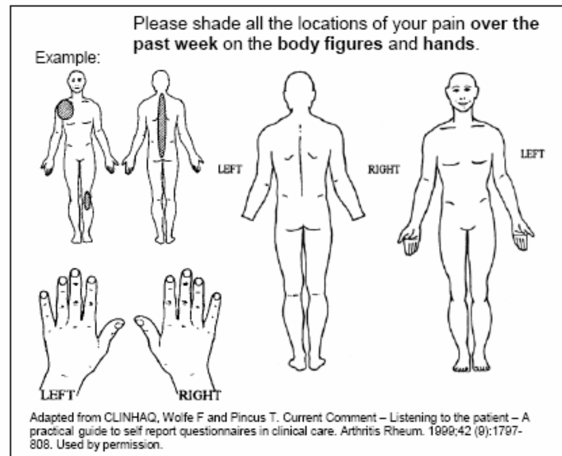

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Allergies: ____________________________________

____

Medications **(including over the counter, vitamins, etc.):**

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Please check any of the following medications that you have already had:

□ Motrin □ Advil □ Aleve	□ Feldene (piroxicam)	□ Prednisone, Medrol	□ Methotrexate
□ Tylenol (acetaminophen)	□ Tolectin (tolmetin)	□ Allopurinol (zyloprim)	□ Imuran (Azathioprine)
□ Aspirin	□ Lodine	□ Colchicine	□ Cytoxan (cyclophosphamide)
□ Celebrex (celecoxib)	□ Daypro (oxaprozin)	□ Probenecid (benemid)	□ Cyclosporine
□ Vioxx (rofecoxib)	□ Orudis, Oruvail (ketoprofen)	□ Gold (shots or pills)	□ Humira
□ Bextra (valdecoxib)	□ Disalcid (salsalate)	□ Plaquenil (hydroxychloroquine)	□ Remicaid
□ Indocin (indomethacin)	□ Trilisate (mag, chlor. trisalicy)	□ Aralen (chloroquine)	□ Enbrel
□ Naprosyn, Anaprox (naproxen)	□ Clinoril (sulindac)	□ Azulfidine (sulfasalazine)	
□ Mobic (meloxicam)	□ Dolobid (diflunisal)	□ Fosamax	
□ Relafen (nabumetone)	□ Arhrotec	□ Actonel	

Physical/Occupational Therapy: ____

Prior Injections: □ Cortisone Injections □ Synvisc Injections □ Hyalgan Injections

what joints?____

Prior Surgery: ____

____

____

Any previous fractures? □ Yes □ No Describe: ______________________________

Any Motor vehicle accidents? □ Yes □ No Describe: __________________________

Any other serious injuries? □ Yes □ No Describe: ____________________________

Past Medical History

Hospitalizations: ____
Major Illnesses: ____
____
____

Please check if you have had any of the following:

□ Arthritis	□ Osteoporosis	□ Asthma	□ Cataracts	□ Pneumonia
□ Miscarriages	□ Bleeding Tendency	□ Lupus	□ Lyme Disease	□ HIV/AIDS
□ Epilepsy	□ Colitis	□ Cancer___________	□ Tuberculosis	□ Back Pain
□ Stomach Ulcers	□ Diabetes	□ Nervous Condition	□ Kidney Disease	□ Aorta Problem
□ Sarcoidosis	□ Gout	□ Heart Problems	□ Stroke	□ Jaundice/Liver
□ Rheumatic Fever	□ Psoriasis	□ Thyroid Problems	□ Glaucoma	□ Seizures

Date of last Mammogram: _________________ Date of last Colonoscopy: ____________________

Date of last Flu vaccine: __________________ Date of last Pneumonia vaccine: _______________

Past Personal/Social History:

Occupation: _____________________

Hours/week: ____________________

Receiving disability: □ Yes □ No

Workman's Comp: □Yes □ No

Occupational Exposure:
□Lead □ Asbestos
Other___________________________

Marital status____________________

Smoker: □Yes □ No packs / day______

Former Smoker: □Yes □ No quit date________

Alcohol (including beer): □ Never
□ Less than once/month □ Less than once/week
□1 to 4 days/week □ More than 4 days/week

Caffeinated Beverages: □Yes □ No Cups/day______

Recreational drugs: □Yes □ No Specify____________

Note: alcohol may interact with some medications

Family History:

Please check all of the diseases which your blood relatives have had and relationship to them:

□ Rheumatoid Arthritis_____________	□ Osteoarthritis____________	□ Other Arthritis ______________
□ Chronic Low Back Pain __________	□ Gout___________________	□ Tuberculosis ________________
□ Diabetes ______________________	□ Psoriasis _______________	□ Osteoporosis ________________
□ Rheumatic Fever _______________	□ Cancer ________________	□ Bleeding Tendency ___________
□ Thyroid Disease ________________	□ Lupus _________________	□ Scleroderma ________________
□ Marfan Syndrome _______________	□ Aorta Problem __________	□ Sarcoidosis _________________

□ **Other** (if not listed above please specify)

□ Father__________________________________ □ Mother__________________________________

□ Siblings____

□ Children____

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____________________

Based on the scale below, which number 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?	□	□	□
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, as 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

Review of Systems:

General
- ◻ Weight loss
Amount____________________
- ◻ Weight gain
- ◻ Wake up feeling unrested
- ◻ Fatigue during the day
- ◻ Weakness
- ◻ Fever/Chills

Muscles/ joints
- ◻ Morning stiffness
Duration____________________
- ◻ Muscle Weakness
- ◻ Muscle pains/aches
- ◻ Joint pains/aches
- ◻ Joint swelling
Joints affected:_______________
____

Eyes
- ◻ Gritty sensation in eyes
- ◻ Dry eyes
- ◻ Red eyes
- ◻ Loss of vision
- ◻ Double vision
- ◻ Blurry vision
- ◻ Pain in the eyes

Ears/Nose/Mouth/Throat
- ◻ Ringing in ears
- ◻ Loss of hearing
- ◻ Pressure in ears
- ◻ Sores in mouth
- ◻ Dry mouth
- ◻ Nosebleeds
- ◻ Freq. sinus problem
- ◻ Sore tongue
- ◻ Loss of taste
- ◻ Bleeding gums
- ◻ Freq. sore throats
- ◻ Hoarseness

Gastrointestinal
- ◻ Nausea
- ◻ Vomiting
- ◻ Loss of appetite
- ◻ Vomiting of blood
- ◻ Difficulty swallowing
- ◻ Pain swallowing
- ◻ Abdominal pain
- ◻ Jaundice
- ◻ Worsening constipation
- ◻ Diarrhea
- ◻ Blood in stool
- ◻ Black, tarry stool
- ◻ Heartburn

Genitourinary
- ◻ Pain/burning w/ urination
- ◻ Frequent urination
- ◻ Difficulty urinating
- ◻ Blood in urine
- ◻ Awaken at night to urinate
- ◻ Kidney stones
- ◻ Pus in urine
- ◻ Discharge from penis/vagina
- ◻ Vaginal dryness

Menstrual
- ◻ Irregular periods
- ◻ Date of last period____________
- ◻ Bleeding after menopause

Cardiovascular
- ◻ Chest Pain
- ◻ Irregular heart beat
- ◻ Pressure in chest
- ◻ Angina
- ◻ Heart Murmur
- ◻ Shortness of breath(exertion)
- ◻ Swollen legs/fluid retention

Psychiatric
- ◻ Nervous Condition
- ◻ Anxiety
- ◻ Crying Spells
- ◻ Depression
- ◻ Ever under Psych. Care?
When? ____________________
- ◻ Hallucinations/voices
- ◻ Feeling of unreality

Hematologic/Lymphatic
- ◻ History of anemia
- ◻ Bleeding tendency
- ◻ Low white blood cells
- ◻ Low platelets
- ◻ Swollen glands
- ◻ Tender glands

Respiratory
- ◻ Shortness of breath
- ◻ Difficulty breathing at night
- ◻ Wheezing/Asthma
- ◻ Cough
- ◻ Coughing blood
- ◻ History of Pleurisy

Skin/Hair/Nails
- ◻ Easy bruising
- ◻ Hives
- ◻ Rash
- ◻ Nodules/lumps
- ◻ Sun sensitive
- ◻ Puffy hands
- ◻ Hair loss
- ◻ Change in fingernails

Neurological
- ◻ Headaches
- ◻ Dizziness
- ◻ Spinning sensation
- ◻ Fainting/blackouts
- ◻ Muscle spasms
- ◻ Numbness
- ◻ Hand/feet tingling
- ◻ Memory loss
- ◻ Sudden loss or "graying" of vision in one eye
- ◻ Seizures

Endocrine
- ◻ Feel cold all the time
- ◻ Feel warm all the time
- ◻ Change in skin color
- ◻ Excessive thirst