MedicalCenter Clinic℠
MUSCULOSKELETAL CENTER

New Patient History Form
Rheumatology Department

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Date of First Appointment: _____ /_____ /_____

Name: _____ Birth date: _____ /_____ /_____
Last First Middle Initial Maiden

Birthplace: _____ Sex: _____ F _____ M

Address: _____
Street Apt. #
_____ Telephone: Home ( ) _____
City State Zip Work ( ) _____

Referred here by: (Check one)
_____ Self _____ Family _____ Friend _____ Doctor _____ Other Health Professional

Name of person making referral: _____ Primary Care Physician: _____

Do you have an orthopedic surgeon? ___ Yes ___No
If yes, name: _____

Date symptoms began (approximate) _____
Briefly describe your present symptoms:
_____
_____
_____

Diagnosis given? (Please list)
_____

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:
_____
_____

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Rheumatologic (arthritis) history

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

Yourself	Blood Relative	Yourself	Blood Relative
_____ Arthritis (type unknown)	_____	_____ Lupusor"SLE"	_____
_____ Osteoarthritis	_____	_____ Anklyosing Spondylitis	_____
_____ Rheumatoid Arthritis	_____	_____Childhood arthritis	_____
_____ Gout	_____	_____ Osteoporosis	_____

Other arthritis conditions: _____

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SYSTEMS REVIEW

Please check all that apply

General:
_____ Recent weight gain/Amount
_____ Recent weight loss/Amount
_____ Fatigue
_____ Weakness
_____ Fever

Nervous system:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands and/or feet
_____ Memory Loss

Ears:
_____ Ringing in ears
_____ Loss of Hearing

Eyes:
_____ Pain
_____ Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feeling of something in your eye

Nose:
_____ Nosebleeds
_____ Loss of smell
_____ Dryness

Mouth:
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

Throat:
_____ Frequent sore throat
_____ Hoarseness
_____ Difficulty in swallowing

Date of last eye examination
_____

Date of last chest X-Ray
_____

Neck:
_____ Swollen glands
_____ Tender glands

Heart and lungs:
_____ Pain in chest
_____ Irregular heart beat
_____ Sudden changes in heartbeat
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ Night sweats

Stomach and intestines:
_____ Nausea
_____ Vomiting of blood or coffee ground material
_____ Stomach pain relieved by food or milk
_____ Yellow jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stool
_____ Heartburn

Kidney/urine/bladder:
_____ Difficult urination
_____ Pain or burning on urination
_____ Cloudy, "Smoky" urine
_____ Pus in urine
_____ Discharge from penis/vagina
_____ Frequent urinations
_____ Getting up at night to pass urine
_____ Vaginal dryness
_____ Rash/ulcers
_____ Sexual difficulties
_____ Prostate trouble

Blood:
_____ Anemia
_____ Bleeding tendency

Date of last Tuberculosis Test
_____

Menstrual:
Age when periods began: _____
Are your periods regular: _____Yes _____No
How many days apart:_____
Date of last period: _____
Date of last Pap Smear: _____
Bleeding after menopause: _____Yes _____No

Skin:
_____ Easy bruising
_____ Redness
_____ Rash
_____ Hives
_____ Sun sensitive (sun allergy)
_____ Tightness
_____ Nodules/bumps
_____ Hair loss
_____ Color changes of hands or feet in cold

Muscles/joints/bones:
_____ Morning stiffness
Lasting how long?
_____ Minutes_____ Hours
_____ Joint pain
_____ Muscle Weakness
_____ Muscle tenderness
_____ Joint swelling:
List joints affected in the last 6 months:
_____
_____

Habits:
Do you drink coffee? _____Yes _____No
Cups per day _____
Do you smoke? _____Yes _____No _____ Past
Cigarettes per day _____
Has anyone ever told you to decrease your drinking?
_____Yes_____ No
Do you use drugs for reasons that are not medical?
_____Yes_____ No If so, please list:
_____
_____

How many pillows do you use to sleep on each night? _____
Do you get enough sleep at night?
_____Yes _____No
Do you wake up feeling rested?
_____Yes _____No

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PAST PERSONAL HISTORY

Do you or have you 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 _____	Breast Prosthesis _____

Other Significant Illness (Please List):
_____

Previous Operations:

	Type	*Year*	*Surgeon*	*City*
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____

Previous fractures? _____ No _____ Yes
Please describe: _____

Other serious injuries? _____ No _____ Yes
Please describe: _____

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FAMILY HISTORY:

Mother: If living, Age _____ Health Status_____
If deceased, Age at death _____ Cause of death_____
Father: If living, Age _____ Health Status_____
If deceased, Age at death _____ Cause of death_____

Number of Brothers _____ Number Living _____ Number Deceased _____
Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children _____ Number Living _____ Number Deceased _____
List ages of each _____
Please list any serious illnesses of children:
_____

Do you know of any blood relative who has or has had: (check and give relationship):

Asthma _____
Alcoholism _____
Bleeding tendency _____
Cancer _____
Colitis _____
Diabetes _____
Epilepsy_____
Goiter _____
Heart Disease _____
High Blood Pressure _____
Leukemia _____
Rheumatic fever_____
Stroke _____
Tuberculosis _____

MARITAL STATUS:

_____ Never Married _____ Married _____ Divorced _____ Separated

SPOUSE: _____ Alive/Age _____ _____ Deceased/Age _____
Major Illnesses: _____

EDUCATION: *(circle highest level attended)*

Grade School:	Junior High School	7	8	9	College	1	2	3	4
	High School	10	11	12	Graduate	_____			

Occupation: _____
Number of hours worked/average per week _____

HOME CONDITIONS:

Check one: _____ House _____ Apartment
Do you have stairs to climb? ____Yes ____No If yes, how many? _____
Number of people in household: _____
Relationship and age of each? _____
Who does the most housework and shopping? _____

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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**	**Okay**	**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?	_____	_____	_____
Walking?	_____	_____	_____
Climbing stairs?	_____	_____	_____
Descending stairs?	_____	_____	_____
Sitting down?	_____	_____	_____
Getting up from the chair?	_____	_____	_____
Touching you 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 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 receiving disability? _____Yes _____ No
Are you applying for disability? _____ Yes _____ No
Do you have a medically related lawsuit pending? _____Yes _____ No

MEDICATIONS

DRUG ALLERGIES: _____ No _____Yes
To which medicine?_____
Type of reaction? _____

Present: (List any medications you are taking at this time. Include items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?	Please check one, did the medication help? Yes	Some	No
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

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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	Did the medication help? Yes	Some	No	Reactions
1. Aspirin					
2. Aspirin – Containing product					
3. Easprin					
4. Disalcid					
5. Tylenol (plain)					
6. Tylenol with codeine					
7. Darvon/Darvocet					
8. Clinoril					
9. Feldene					
10. Indocin					
11. Meclomen					
12. Motrin/Rufen					
13. Nalfon					
14. Naprosyn					
15. Tolectin					
16. Cortisone/Prednisone					
17. Benemid					
18. Colchicine					
19. Zyloprim/Lopurin					
20.Gold (Shots or Pills)					
21. Palquenil					
22. Penicillamine					
23. Methotrexate					
24. Imuran					
25. Cytoxan					
26. Other					
27. Other					
28. Other					