Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

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Rheumatology History Form

Name: _____ Date:_____
Referring Physician: _____ Date of Birth: _____

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you:

General	Yes	Cardiovascular	Yes	Genitourinary	Yes
Fever or chills		Chest pain		Frequent urination	
Cold Fingers		Palpitations		Blood in urine	
Recent weight change		Feet, ankle, swelling		Genital ulcers	
Fatigue/Tiredness		**Lungs**	**Yes**	**Gastrointestinal**	**Yes**
Heat or cold intolerance		Cough		Constipation	
Loss of appetite		Shortness of breath		Abdominal pain	
Head and Neck	**Yes**	Wheezing		Heartburn/Indigestion	
Recent trauma		**Musculoskeletal**	**Yes**	Frequent diarrhea	
Swelling in neck		Swollen/red joints		Difficulty swallowing	
Prolonged hoarseness		Arm/leg weakness		Nausea or vomiting	
Pain or stiffness in neck		Leg ulcers		**Endocrine**	**Yes**
Skin	**Yes**	Difficulty in walking		Excessive sweating	
Skin nodules		**Neurologic**	**Yes**	Excessive thirst	
Rash, dryness, itching		Light headed/dizziness		**Psychiatric**	**Yes**
Change in nails or skin color		Numbness/tingling		Depression	
Hair loss		Frequent headaches		Anxiety	
Eyes	**Yes**	Memory difficulties		Anorexia/bulimia	
Glasses or contacts		Sleep disorders		Nervous breakdown	
Red eyes		**Ears, Nose, Mouth**	**Yes**	Physical, verbal or sexual abuse	
Dry eyes		Dry mouth			
Extreme sensitivity to light		Nose bleeds		Other	
		Runny nose			
		Ear ache			

Past and Family Medical History: Please check if you or your family have ever had any of the following

	You	Family		You	Family		You	Family
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Kidney Disease			Vision Problems		
Psoriasis			Blood Disorders			Hearing Problems		
Stroke			Lupus			Low back pain		
Gout			Other			Other		

Please list any recent hospitalizations, broken bones or surgeries, and an approximate date

Date	Reason for hospitalization or surgery

Please list all of your medications, including over the counter medications (If you need additional space please bring a list, including dosages, to your appointment.)

Name of Medication	Dosage	Number of Times Per Day	Reason for Medication

Please list all allergies including medications, food, and environmental

Medication, Food, Other	Reaction

Social History:

Marital Status: Single _____ Divorced _____ Married _____ Widow/Widower _____ Other _____
Who lives at home with you? _____Education completed _____
Current Occupation/Employer:_____
Do you smoke? Yes _____ No _____ If yes, how many packs per day?_____
Did you smoke? Yes _____ No _____ If yes, when did you quit? _____
How much alcohol do you drink per week? Mixed drinks _____ Beer _____ Wine _____

Please answer the following questions:

What symptoms bring you into see the doctor?_____
What joints or muscles are specifically bothering you?_____
When did each of the pains begin?_____
When you get up in the morning, how long (minutes or hours) does it take before your stiffness is as good as it is going to get?_____
Do you experience any pain at rest? _____ If yes, where?_____
Do your pains wake you up at night? _____ Do any activities worsen your pain? _____
Is there anything you can do to make your pain better? _____
Was the onset of your pain associated with an illness? (flu, virus) _____
On a scale of 1 to 10, rate how severe your pain is

0	1	2	3	4	5	6	7	8	9	10
Not very severe pain					Moderately severe pain				Extremely severe pain	

Are your symptoms interfering with your activities either at home or at work? _____
If yes, please describe in detail? _____
_____
Are you having trouble sleeping? _____ In the past 6 to 12 months have you gained or lost weight?_____
List any medications you have tried for your present symptoms: _____
_____
_____

FEMALE PATIENTS:

Do you have regular periods? _____ Age of Menopause _____
How many pregnancies have you had? _____ Births_____ Miscarriages_____ Are you pregnant?_____

Patient Signature_____Date_____
Physician Signature _____Date_____