



**Muncie** 2525 University Ave., Suite 300 Muncie, IN 47303 ph 765•281•2000 fx 765•281•2040  
**Muncie** 800 S. Tillotson Ave. Muncie, IN 47304 ph 765•281•2000 fx 765•281•2044  
**Cancer Center** 2401 University Ave. Muncie, IN 47303 ph 765•281•2000 fx 765•281•2114  
**Marion** 1399 N. Baldwin Marion, IN 46952 ph 765•651•2620 fx 765•651•2630  
**New Castle** 2200 Forest Ridge, Suite 120 New Castle, IN 47362 ph 765•593•2960 fx 765•593•2965  
**New Castle** 1000 North 16th, Suite 240A New Castle, IN 47362 ph 765•521•1461

Patient Focused • Quality Oriented • Physician Driven

### 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		<b>Lungs</b>	<b>Yes</b>	<b>Gastrointestinal</b>	<b>Yes</b>
Heat or cold intolerance		Cough		Constipation	
Loss of appetite		Shortness of breath		Abdominal pain	
<b>Head and Neck</b>	<b>Yes</b>	Wheezing		Heartburn/Indigestion	
Recent trauma		<b>Musculoskeletal</b>	<b>Yes</b>	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		<b>Endocrine</b>	<b>Yes</b>
<b>Skin</b>	<b>Yes</b>	Difficulty in walking		Excessive sweating	
Skin nodules		<b>Neurologic</b>	<b>Yes</b>	Excessive thirst	
Rash, dryness, itching		Light headed/dizziness		<b>Psychiatric</b>	<b>Yes</b>
Change in nails or skin color		Numbness/tingling		Depression	
Hair loss		Frequent headaches		Anxiety	
<b>Eyes</b>	<b>Yes</b>	Memory difficulties		Anorexia/bulimia	
Glasses or contacts		Sleep disorders		Nervous breakdown	
Red eyes		<b>Ears, Nose, Mouth</b>	<b>Yes</b>	Physical, verbal or sexual abuse	
Dry eyes		Dry mouth		Other	
Extreme sensitivity to light		Nose bleeds			
		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

