Athens Rheumatology Clinic, LLC
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PATIENT HISTORY FORM

Date of first appointment: / / Time of appointment: _____ Birthdate: _____

Name_____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ❑ F ❑ M
STREET

_____ Telephone: Home (____)_____
CITY STATE ZIP Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

EDUCATION (Circle highest level attended) Grade School 7 8 9 10 11 12 College 1 2 3 4

Social Security _____ Occupation _____ Number of Hours worked _____

Referred by: (Check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor **Language** used: _____

Name of person making referral: _____

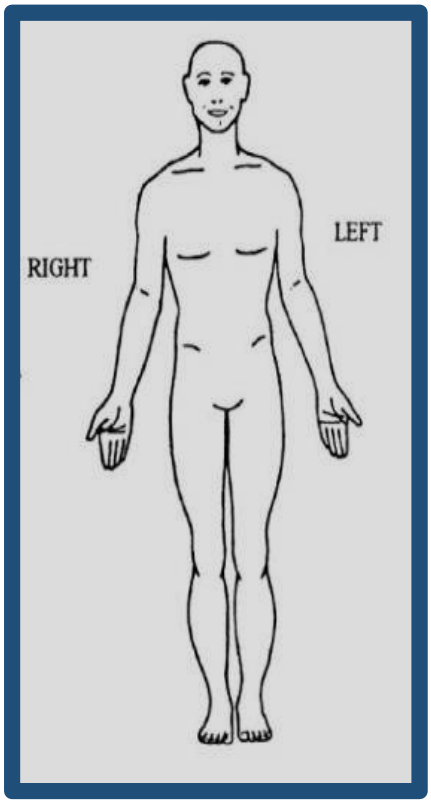
Name the physician providing your primary medical care: _____

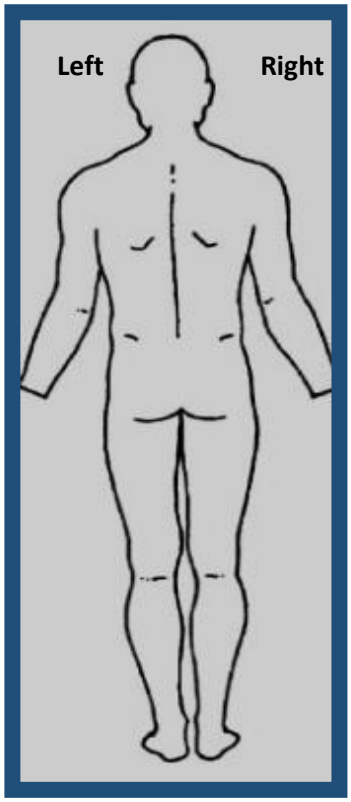
Describe your **present symptoms:** _____
_____

Symptoms began when: _____

Have you been treated with any of the following?
(Physical therapy, Surgery and Injections; <u>Medications</u>
_____
_____
_____
_____

Have any other doctor seen you for this problem?
_____
_____
_____
_____
_____
_____





RHEUMATOLOGIC (ARTHRITIS) HISTORY

Have **(You or Family Member**) had any of the following? (Check if "yes")

Yourself		Family Member	Yourself		Family member
	Arthritis			**Lupus or "SLE"**	
	Osteoarthritis			**Rheumatoid Arthritis**	
	Gout			**Ankylosing Spondylitis**	
	Childhood arthritis			**Osteoporosis**	
Other arthritis:					

Date of last eye exam _____Date last chest x-ray _____

Date of last Tuberculosis Test _____ Date of last bone densitometry_____

SYSTEMS REVIEW: Please check any problems, which affects you.

Any Major

- ❑ weight gain _____
- ❑ weight loss _____
- ❑ Fever
- ❑ Fatigue / Weakness

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood
- ❑ Stomach pain
- ❑ Jaundice
- ❑ Constipation
- ❑ Persistent diarrhea
- ❑ Bloody or Black stools
- ❑ Heartburn

Integumentary (skin and breast area)

- ❑ Easy Bruising
- ❑ Redness
- ❑ Rash or Hives
- ❑ Nodules/bumps
- ❑ Sun sensitive
- ❑ Hair loss
- ❑ Color change in hands / feet in the cold

Eyes

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness / Itching
- ❑ Feels like something in eye

Genitourinary

- ❑ Blood in urine
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Rash/ Ulcers
- ❑ Cloudy or Pus in urine
- ❑ Kidney disease
- ❑
- ❑ Discharge from penis/vagina
- ❑ Prostate trouble
- ❑ Sexual difficulties

Neurological System

- ❑ Stroke
- ❑ Dizziness or Fainting
- ❑ Memory loss
- ❑ Muscle spasm
- ❑ Nervous breakdown
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands or feet
- ❑ Epilepsy

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose or mouth
- ❑ Loss of taste ❑ Agitation

Thyroid Problem

- ❑Hyperthyroid
- ❑ Hypothyroid

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ High blood pressure
- ❑ Heart attack

Musculoskeletal

- ❑ Morning stiffness
- ❑ Muscle weakness
- ❑ Joint swelling
- ❑ Joint pain

For Women only:

Periods regular? ❑Yes ❑No Date of last pap?_____ & Date of last period? _____

Date of last mammogram_____ Have you had any bleeding after menopause? ❑Yes ❑No

Number of miscarriages? _____ and Number of Pregnancies?_____

- ❑ Have you had Blood Transfusion-when/ and where:_____

SOCIAL HISTORY

- ❑ How much coffee do you drink? _____
- ❑ Do you smoke? ❑ Yes ❑ No ❑ How long? _____
- ❑ Do you drink alcohol? ❑ Yes ❑ No Number per week _____
- ❑ Do you use drugs for reasons that are not medical? ❑ Yes ❑ No -If yes, please list: _____
- ❑ Do you exercise regularly? ❑ Yes ❑ No
- ❑ How many hours of sleep do you get at night? _____

Do you have an **orthopedic surgeon**? ❑ No ❑ Yes- if yes, **Name:** _____
Please list any orthopedic surgeries:

Any previous fractures? ❑ Yes ❑ No Describe:_____

Any other serious injuries? ❑ Yes ❑ No Describe:_____

Emergency Contact:_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

MEDICATIONS Name of Drug	Dose (include strength & number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Pharmacy: Name and Number_____

Drug Allergies? ❑ No ❑ Yes: To what and its reaction?

_____

_____

Can you do the following:	**No Problems**	**Some Problems**	**Unable to do**
a. Write, and dress yourself?	_____0	_____1	_____2
b. Get in and out of the car?	_____0	_____1	_____2
c. Lifting a plate and cook?	_____0	_____1	_____2
d. Walking for 2-4 hours?	_____0	_____1	_____2
f. Bending elbow, hip and knees with any problems?	_____0	_____1	_____2
g. Turn the shower on and off?	_____0	_____1	_____2

How severe is your pain:

○ ○ ○ ○ ○ ○

No pain 0 1 2 3 4 5 **Very** Bad