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

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

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 symptoms: _____

Symptoms began when: _____

Have you been treated with any of the following?
(Physical therapy, Surgery and Injections; Medications

_____

_____

_____

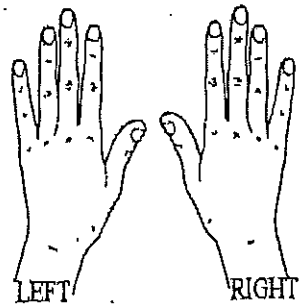
_____

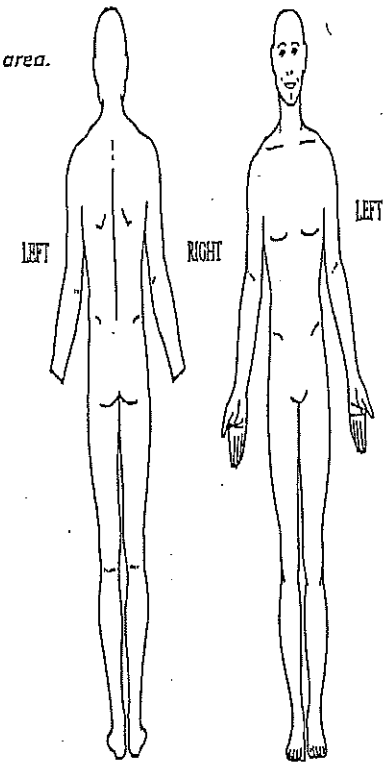
Have any other doctor seen you for this problem?

_____

_____

Please Shade- all of your pain area.





☐ Sores in mouth

☐ Difficulty in swallowing

For Women only:

Periods regular? ☐Yes ☐No Date of last pap? 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 serious injuries? ☐ Yes ☐ No Describe: _____

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 affect you.

Any Major
- ☐ weight gain _____
- ☐ weight loss _____
- ☐ Fever
- ☐ Fatigue / Weakness

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

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose or mouth
- ☐ Loss of taste
- ☐ Sore tongue
- ☐ Bleeding gums

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

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

Thyroid Problem
- ☐ Hyperthyroid
- ☐ Hypothyroid

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Heart attack

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

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

Musculoskeletal
- ☐ Morning stiffness
- ☐ Muscle weakness
- ☐ Joint swelling
- ☐ Joint pain

MEDICATIONS Allergies? ☐ No ☐ Yes: To what_____ and its reaction? _____

_____

_____

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

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

Circle how severe your pain is on a level of 5:

O O O O O O

No pain 0 1 2 3 4 5 Very Bad

Pharmacy Name: _____ Number:_____ Location:_____

Athens Rheumatology Clinic

Please list all medical conditions

- Diabetes-

-Hypertension-

-Heart disease-

-Lung disease-.

-Kidney problems-

-Lung problems-

Please List all Surgeries/ procedures

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-

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-

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