

RHEUMATOLOGY AND HISTORY & PHYSICAL

Date: _____

Name: _____ Age: _____ Marital Status: S ___ M ___ W ___ D ___

Occupation: _____

Current Medications: _____

Drug Allergies: _____

PAST PERSONAL HISTORY: Do you have or have you had: (Check if "yes")

___ Cancer ___ Heart Problems ___ Asthma/Emphysema ___ Thyroid Disease
___ High Blood Pressure ___ Stroke ___ Cataracts ___ Diabetes
___ Epilepsy ___ Nervous breakdown ___ Stomach ulcers ___ Rheumatic Fever
___ Bad Headaches ___ Jaundice ___ Colitis ___ Kidney Disease
___ Pneumonia ___ Psoriasis ___ Anemia ___ Gout
___ Melanoma ___ Diverticulitis ___ Hepatitis ___ TB

Recent weight loss _____ Other significant illness _____

HOSPITALIZATIONS: Type of Illness or Operation/Surgeries _____ Year _____

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Any Previous Fractures? [] No [] Yes Describe: _____

Cigarettes/Day _____ Alcohol/ounces per week _____

FAMILY HISTORY: If Living _____ If Deceased _____

	Age	Health	Age at Death	Cause
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Father _____

Mother _____

Serious Illnesses of Children/Siblings/Parents: _____

HOME CONDITIONS: Check One: [] House [] Apartment

Do you have stairs to climb? [] Yes [] No. If yes, how many _____

Number of people in household _____ Relationship _____

Who does most of the housework? _____

THIS SIDE IS FOR THE PHYSICIAN, PLEASE DO NOT WRITE ON THIS SIDE

CHIEF COMPLAINT: _____

HPI:

RECORDS REVIEW _____

RHEUMATOLOGY SYMPTOM REVIEW:

- | | | |
|--|--|---|
| <input type="checkbox"/> Rash/Tick Bite | <input type="checkbox"/> Dry Eyes or Mouth | <input type="checkbox"/> Urethral Discharge |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Psoriasis/IBD |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Raynaud | <input type="checkbox"/> Tender Scalp | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Ocular Inflammation | <input type="checkbox"/> Jaw Claudication | <input type="checkbox"/> Disturbed Sleep |
| <input type="checkbox"/> Mucosal Ulcers | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Stress/Anxiety |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> LBP | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Serositis | <input type="checkbox"/> Keratoderma | <input type="checkbox"/> AM Stiffness |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Belanitis | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> CNS/Psychiatric | <input type="checkbox"/> Heel Pain | <input type="checkbox"/> Lab |
