

RHEUMATOLOGY HISTORY & PHYSICAL

Date: _____

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

Occupation: _____

Current Medications: _____

DRUG ALLERGIES: _____

PAST PERSONAL HISTORY: Do you 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

Recent weight loss _____ Other significant illness _____

HOSPITALIZATIONS: Type of illness or Operation	Year
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____
7) _____	_____

Any previous fractures? [] No [] Yes Describe: _____

Cigarettes/Day: _____ Alcohol/oz-wk: _____

FAMILY HISTORY:	If Living	If Deceased
Age	Health	Age at Death Cause

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? _____