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? _____