RHEUMATOLOGY AND 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
_____Melanoma	_____Diverticulitis	_____Hepatitis	_____TB

Recent weight loss_____Other significant illness_____

HOSPITALIZATIONS: Type of illness or Operation Year

1)_____ _____

2)_____ _____

3)_____ _____

4)_____ _____

5)_____ _____

6)_____ _____

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? _____

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

CHIEF COMPLAINT:_____

_____

_____

HPI:

_____

_____

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_____

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_____

RECORDS REVIEW_____

_____

RHEUMATOLOGY SYMPTOM REVIEW:

_____Rash/Tick bite	_____Dry Eyes or Mouth	_____Urethral Discharge
_____Photosensitivity	_____Muscle weakness	_____Psoriasis/IBD
_____Alopecia	_____Muscle Pain	_____Tendonitis
_____Raynauds	_____Tender Scalp	_____Bursitis
_____Ocular inflammation	_____Jaw Claudication	_____Disturbed Sleep
_____Mucosal Ulcers	_____Double Vision	_____Stress/Anxiety
_____Dysphagia	_____LBP	_____Cortisone
_____Serositis	_____Keratodermia	_____AM Stiffness
_____Kidney Disease	_____Belanitis	_____X-Ray
_____CNS/Psychiatric	_____Heel Pain	_____Lab