



AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: ____ / ____ / ____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: ____ / ____ / ____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: F M
STREET APT#
CITY STATE ZIP Telephone: Home (____) _____
Work (____) _____

MARITAL STATUS: Never Married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age ____ Deceased/Age ____ Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) Self Family Friend Doctor Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? Yes No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____ Example _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

LEFT RIGHT LEFT RIGHT LEFT RIGHT

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself	Relative Name/Relationship	Yourself	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____
Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- Recent weight gain
amount _____
- Recent weight loss
amount _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

Ears--Nose--Mouth--Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

Gastrointestinal

- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For Women Only:

- Age when periods began: _____
- Periods regular? Yes No
- How many days apart? _____
- Date of last period? ____/____/____
- Date of last pap? ____/____/____
- Bleeding after menopause? Yes No
- Number of pregnancies? _____
- Number of miscarriages? _____

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst
- Hematologic/Lymphatic**
- Swollen glands
 - Tender glands
 - Anemia
 - Bleeding tendency
 - Transfusion/when _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
 Cups/glasses per day? _____
 Do you smoke? Yes No Past – How long ago? _____
 Do you drink alcohol? Yes No Number per week _____
 Has anyone ever told you to cut down on your drinking?
 Yes No

Do you use drugs for reasons that are not medical? Yes No
 If yes, please list: _____

Do you exercise regularly? Yes No
 Type _____
 Amount per week _____
 How many hours of sleep do you get at night? _____
 Do you get enough sleep at night? Yes No
 Do you wake up feeling rested? Yes No

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? No Yes Describe: _____
 Any other serious injuries? No Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____
 Number of children _____ Number living _____ Number deceased _____ List ages of each _____
 Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, *how long* you were taking the medication, the *results* of taking the medication and list any *reactions* you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Circle any you have taken in the past					
Asaoid (flurbiprofen)	Arthrotec (diclofenac + misoprostil)	Aspirin (including coated aspirin)	Celebrex (celecoxib)	Clinoril (sulindac)	
Daypro (oxaprozin)	Disalcid (salsalate)	Dolobid (diflunisal)	Feldene (piroxicam)	Indocin (indomethacin)	Lodine (etodolac)
Meclomen (meclofenamate)	Motrin/Rufen (Ibuprofen)	Naifon (fenopropfen)	Naprosyn (naproxen)	Oruvail (ketoprofen)	
Tolectin (toimetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac)		
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Mycophrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin Injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

Have you participated in any clinical trials for new medications? Yes No

If yes, list: _____

Are you receiving disability? Yes _____ No _____

Are you applying for disability? Yes _____ No _____

Do you have a medically related lawsuit pending? Yes _____ No _____

Form A102