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RHEUMATOLOGIC HISTORY QUESTIONNAIRE

Please answer all questions. If you do not understand the question, insert a question mark. There are 6 pages. Please fill out everything to the best of your ability.

Patient Name:_____ Date:_____

Occupation:_____ Referred by:_____

Right or Left Handed:_____DOB:_____

PRESENT ILLNESS:

1. Describe your most distressing symptoms in detail:

_____

_____

_____

_____

   a. How long have your symptoms been present?_____
   b. Was the onset sudden or gradual?_____
   c. What is the location of your symptoms?_____
   d. Are they intermittent or constant? _____
   e. Frequency and duration of symptoms?_____
   f. Progressively increasing or decreasing?_____
   g. Aggravating factors?_____
   h. Relieving factors?_____

2. Do your symptoms affect your:
   a. Ability to work through the months or years?_____
   b. Ability to do house hold chores?_____
   c. Activities of daily living and personal care?_____
   d. Ability to participate in sports?_____
   e. Need for cane, crutches or wheelchair?_____
   f. Need for hospitalization or home confinement?_____

3. How many hours do you sleep?_____
    a. Are you tired when you wake up?_____
    b. Do your symptoms affect your sleep?_____
4. Duration of morning stiffness?_____
5. Do you believe that:
    a. Emotional ups and downs affect your problems?_____
    b. Your problems affect your emotions?_____
    If yes, how?_____
6. Psychosocial consequences:
    a. Anxiety, depression, insomnia?_____
    b. Economic impact of handicap?_____
    c. Use of community resources?_____

PREVIOUS INVESTIGATIONS:

X-Rays:_____

MRI: _____

CT Scan:_____

Blood Tests:_____

Other:_____

_____

PREVIOUS DIAGNOSES:

	Date	Doctor	Diagnosis
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

PREVIOUS TREATMENTS:

Have you ever been given any of the following medications? Please indicate below.

	Dosage	Date	Side-Effects	Does it Help?	Compliance
___Aspirin					
___Advil					
___Alleve					
___Motrin					
___Indocin					
___Mobic					
___Clinoril					
___Naproxen					
___Voltaren					
___Ansaid					
___Relafen					
___Daypro					
___Celebrex					
___Lodine					
___Colchicine					
___Prednisone					
___Medrol					
___Cortisone Injections					
___Cytoxan					
___Immuran					
___Cellcept					
___Methotrexate					
___Plaquenil					
___Dapsone					
___Neoral					
___Arava					
___Allopurinol					
___Benemid					
___Diuretics					

	Dosage	Date	Side-Effects	Does it Help?	Compliance
___Enbrel					
___Humira					
___IV Remicade					
___IV Rituxan					
___IV Orencia					
___Zocor					
___Lipitor					
___Crestor					

Osteoporosis

Medications:	Dosage	Date	Side-Effects	Does it Help?	Compliance
___Estrogens (Premarin)					
___Fosamax					
___Actonel					
___Boniva					
___IV Boniva					
___IV Reclast					
___Calcitonin					
___Evista					
___Forteo					

Joint Injections:	Dosage	Date	Side-Effects	Does it Help?	Compliance
___Hyalgan					
___Synvisc					
___Supartz					
___Cortisone					

Current Medications: (List all over the counter meds)

1. Medication	Dosage	Date	Side-Effects	Does it Help?	Compliance

2. Have you ever received instruction or treatment in any of the following area by a physical therapist, nurse or a pain treatment center? Please indicate below:

Treatment	Date	Helpful or Not?
___Traction	_____	_____
___Heat Massage, Ultrasound	_____	_____
___Exercise, Posture	_____	_____
___Relaxation Techniques	_____	_____
___Transcutaneous Neurostimulation	_____	_____
___Biofeedback	_____	_____
___Behavior Modification	_____	_____
___Educational Films or Booklets	_____	_____

3. Have you received any other forms of treatment diet, acupuncture, chiropractor, etc.? If so, have they been helpful?

_____

_____

4. What is your level of understanding of your disease and expectations?

_____

_____

Medical History:

1. Check the appropriate word:

General Health	□ Excellent	□ Good	□ Fair	□ Poor
Weight in last year	□ Stable	□ Gain	□ Loss	□ Amount _____

2. Hospitalizations:

Hospital Name	Year	Reason	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Other medical problems: _____

_____

4. Surgical procedures:

Hospital Name	Year	Type	Helpful or Not?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Family history of Arthritis or other Rheumatic Diseases:

_____

_____

6. Social History:

Work Activities:_____

Accidents, Trauma, Previous Fractures:_____

Sexual History:_____

Tick Bite:_____

Recent Travel:_____

AIDS, Hepatitis:_____

REVIEW OF SYSTEMS:

1. Check the complaints:

Skin:	□ Rashes	□ Mouth Sores	□ Loss of Scalp Hair	□ Psoriasis
	□ Nail Changes	□ Ulcers	□ Color Change	□ Pigmentation
	□ Nodules	□ Contractures	□ Sun Sensitivity	□ Tightening
	□ Raynauds' Phenomenon		□ Cold Sensitivity	
Joints:	□ Location_____		□ Character of Pain_____	
	□ Swelling		□ Morning Stiffness	□ Warmth
	□ Limitation of Motion		□ Redness	
Head & Neck:	□ Change in Voice		□ Swollen Neck Glands	□ Jaw Pain
	□ Neck Pain		□ Tender Scalp	□ Deafness
	□ Painful or red eyes		□ Double Vision	□ Dryness of Mouth and Eyes
	□ Impaired Vision/Loss of Vision		□ Difficulty swallowing	□ Frequent Sinusitis
	□ Hoarseness		□ Nosebleeds	
Chest:	□ Cough	□ Phlegm	□ Difficulty Breathing	□ Chest Pain
	□ Wheezing	□ Pneumonia	□ Bronchitis	□ Coughing of Blood
Hematologic:		□ Swollen Glands	□ Anemia	□ Bleeding Tendency

RHEUMATOLOGIC HISTORY

Abdomen: □ Heartburn □ Abdominal Pain □ Vomiting □ Ulcers
□ Diarrhea □ Rectal Bleeding □ Blood in Stool □ Colitis
□ Constipation □ Hepatitis/Jaundice

Muscle Weakness: □ Difficulty Climbing Stairs □ Getting up from a chair
□ Combing you hair □ Difficulty lifting head off the pillow
□ Wasting of Muscles

Urinary: □ Painful Urination □ Bloody or Cloudy Urine
□ Frequency □ Urethritis □ Vaginal or Penile Discharge
□ Prostatitis □ Stones □ Kidney Disease □ Flank Pain

Neurologic: □ Recurrent Headaches □ Loss of Consciousness
□ Convulsions or Seizures □ Difficulty with Memory
□ Numbness or Tingling □ Hallucinations
□ Stroke □ Paralysis □ Weakness □ Disorientation

Others: □ Fever □ Night Sweats □ Chills □ Fatigue
□ Depression □ Anxiety □ Tension □ Cramps

2. List dates and results of the following exams:

Last eye exam _____ Results_____

Last Chest X-Ray _____ Results_____

TB Skin Test_____ Results_____

Last Bone Density_____ Results_____

3. List allergy/reaction to Aspirin, Penicillin or any other drug. Please indicate kind of allergic reaction.

_____

_____

4. Personal: Smoke □ Yes □ No How many per day?_____
Alcohol □ Yes □ No How much?_____

Please use these additional lines for any comments you wish to make regarding your problems.

_____

_____

_____

_____ _____
Patient Signature Date

Physical Examination: To be completed by doctor

Joints:

T-M

SHOULDERS

ELBOWS

WRISTS

Hands:

MCP

PIP

DIP

HIPS:

KNEES:

ANKLES:

FEET:

S-T

MTP

PIP

DIP

SPINE:

CERVICAL

THORACIC

LUMBAR

SACROILIAC

COCCYX

POSTURE:

GAIT:

Skin –

ENT –

Chest –

Heart –

Abdomen –

Neurologic –

Muscle

DIAGNOSIS:

PLAN:

Sig: