PRINCETON MEDICAL GROUP

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

Name: _____

Last First M.I.

Date of birth: ____/____/____ Age: _____ Gender at birth: ☐ F ☐ M Current Gender: _____

Marital Status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Partnered/Significant Other

Referring physician: _____ Primary Care Physician: _____

Pharmacy (name & address): _____

_____

Reason for visit (briefly describe your present symptoms): _____

_____

_____

When did your symptoms start? _____

What diagnosis have you been given, if any? _____

_____

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

_____

Previous treatment for this problem (include physical therapy, surgery, injections and any medications)

_____

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	Relationship
Arthritis (type unknown)	❑	❑	_____
Osteoarthritis	❑	❑	_____
Rheumatoid arthritis	❑	❑	_____
Gout	❑	❑	_____
Lupus or "SLE"	❑	❑	_____
Ankylosing spondylitis	❑	❑	_____
Childhood arthritis	❑	❑	_____
Sjogren's syndrome	❑	❑	_____
Osteoporosis	❑	❑	_____
Psoriasis/psoriatic arthritis	❑	❑	_____

PAST MEDICAL HISTORY

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

❑ Diabetes	❑ Hepatitis	❑ Anemia
❑ High blood pressure	❑ DVT/Pulmonary embolism	❑ Colitis
❑ High cholesterol	❑ Asthma/COPD	❑ Crohn's disease
❑ Hypothyroidism	❑ Stroke	❑ Stomach or peptic ulcer
❑ Goiter	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Cancer (type) _____	❑ Cataracts	❑ Tuberculosis
❑ Heart problems	❑ kidney disease	❑ HIV/AIDS
❑ Psoriasis	❑ Kidney stones	

Other significant illnesses (please list):

PAST SURGICAL HISTORY (list all surgeries/operations)

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			

PERSONAL AND SOCIAL HISTORY

What is your highest educational level? ☐ High school ☐ Some college courses ☐ College graduate

☐ advanced degree

What is your current occupation? _____

Are you currently working? ☐ Yes ☐ No If yes, hours/week: _____ If no, ☐ retired ☐ disabled ☐ sick leave

How much exercise do you get each week? _____

What kind of exercise? _____

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

Do you smoke? ☐ No ☐ Yes Describe: _____

Do you drink alcohol? ☐ No ☐ Yes Describe: _____

Do you drink caffeinated beverages? ☐ No ☐ Yes Describe: _____

Do you use drugs for reasons that are not medical?

☐ No ☐ Yes Describe: _____

FAMILY HISTORY (list all diseases that your blood relatives have or had in the past)

Father: _____

Mother: _____

Sisters: _____

Brothers: _____

Others: _____

_____

DRUG ALLERGIES

☐ None ☐ Yes To what and type of reaction? _____

_____

_____

MEDICATIONS

List any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	**Dose (include strength and number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

SYSTEMS REVIEW

Date of last eye exam: _____ Date of last chest X-Ray: _____

Date of last bone density test: _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date performed: _____

Check off if you have ever experienced

GENERAL
☐ Recent weight gain, how much___
☐ Recent weight loss, how much___
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

MUSCLE/JOINT/BONES
☐ Morning stiffness
Lasting how many min. _____
Lasting how many hr. _____
☐ Joint Pain
☐ Muscle Pain
☐ Joint swelling
List joints affected - last 6 months
_____
_____
_____
_____

EARS
☐ Ringing in ears
☐ Loss of hearing

EYES
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness

MOUTH
☐ Sore tongue
☐ Bleeding gums
☐ Sores in mouth
☐ Loss of taste
☐ Dryness
☐ Recent increase in tooth cavities

NOSE
☐ Nosebleeds
☐ Loss of smell

THROAT
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty swallowing
☐ Pain in jaw while chewing

NECK
☐ Swollen glands
☐ Tender glands

HEART AND LUNGS
☐ Pain In chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ Shortness of breath
☐ Difficulty breathing at night
☐ Swollen legs or feet
☐ Cough
☐ Coughing up blood
☐ Wheezing

STOMACH AND INTESTINES
☐ Nausea
☐ Heartburn
☐ Stomach pain relieved by food
☐ Vomiting of blood
Looks like “coffee grounds:
☐ Yellow jaundice
☐ Increased constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

KIDNEY/URINE/BLADDER
☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Cloudy “smoky” urine
☐ Pus in urine
☐ Frequent urination
☐ Get up late night to urinate

BLOOD
☐ Anemia
☐ Bleeding tendency

SKIN
☐ Bruising easily
☐ Redness
☐ Rash
☐ Hives
☐ Sun Sensitive
☐ Skin tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color change in hands or feet in the cold (Raynaud’s)

NERVOUS SYSTEM
☐ Headaches
☐ Dizziness
☐ Fainting/loss of consciousness
☐ Numbness or tingling in hands or feet
☐ Memory loss
☐ Muscle weakness

PSYCHIATRIC
☐ Depression
☐ Excessive worries
☐ Difficulties falling asleep
☐ Difficulties staying asleep

REPRODUCTIVE
☐ Rashes or ulcers
☐ Sexual difficulties
☐ Prostate Trouble
☐ Vaginal dryness

WOMEN ONLY
Number of miscarriages: _____
☐ 2nd or 3rd trimester miscarriages

Have you reached menopause
☐ No
☐ Yes, at what age_____