PATIENT PAST HISTORY

TODAY'S DATE: ____________

Patient Name: ________________________________ Age: _______ Date of Birth: ____________

REASON FOR TODAY'S VISIT: ____

PAST MEDICAL HISTORY (Check if "yes")

_____	*Psoriasis*	_____	*High blood pressure*	_____	*Anemia*
_____	*Iritis/scleritis*	_____	*Heart disease*	_____	*Blood transfusion*
_____	*Sinusitis*	_____	*Stomach ulcer*	_____	*Blood clots*
_____	*Asthma*	_____	*Duodenal ulcer*	_____	*Raynaud's phenomenon*
_____	*Emphysema*	_____	*Crohn's disease*	_____	*Migraine headache*
_____	*Pneumonia*	_____	*Ulcerative colitis*	_____	*Epilepsy/seizure disorder*
_____	*Thyroid disease*	_____	*Irritable bowel syndrome*	_____	*Stroke/TIA*
_____	*Diabetes mellitus*	_____	*Hepatitis/liver disease*	_____	*Muscle disease*
_____	*Osteoporosis*	_____	*Kidney disease/Stone*	_____	*Nerve disease*
_____	*Broken bone(s)*	_____	*HIV/AIDS*	_____	*Psychiatric disease*
_____	*Cancer*	_____	*Sexually-transmitted disease*	_____	*Drug or alcohol abuse*

Any Other conditions not listed: ____

SURGERIES OR OVERNIGHT HOSPITALIZATIONS
Describe the reason for hospitalization or operation
IF N/A PLEASE INDICATE – please use back if additional space required

	Reason	RIGHT OR LEFT	Year
1.	______________________________	R / L	______
2.	______________________________	R / L	______
3.	______________________________	R / L	______
4.	______________________________	R / L	______
5.	______________________________	R / L	______
6.	______________________________	R / L	______

CURRENT MEDICATIONS AND DOSAGE (All medications including over the counter)

1. ______________	5. ______________	9. ______________
2. ______________	6. ______________	10. ______________
3. ______________	7. ______________	11. ______________
4. ______________	8. ______________	12. ______________

DRUG ALLERGIES ____

No Known Drug Allergies ☐

FAMILY HISTORY

	Alive/Deceased	Medical diseases and/or conditions
Mother	______________	______________________________
Father	______________	______________________________
Sister(s)	______________	______________________________
Brother(s)	______________	______________________________

SOCIAL HISTORY

Highest level of education: _____ *Occupation:* ______________ *Disabled? No Yes*
Marital status (circle one): never married married divorced widow (er) *Number of children:* _____
Do you use any tobacco product? No Yes Do you drink alcohol? No Yes Do you use any other drug? No Yes
Religion: ______________ Hobbies you enjoy: ______________
How many people live in your home? _______ Who does most of your housework? ______________
I live in a ... (circle one) House Condo Apartment Do you have stairs to climb at home? No Yes
What sports do you play?

Sign: ______________________________

HISTORY OF PRESENT ILLNESS

(this page to be completed by the physician)

CHIEF COMPLAINT ____________________

HISTORY ____________________

JOINT REVIEW

R L DIP 2 3 4 5	R L Elbow	R L Hip	R L SI	Motor Def.
R L PIP 2 3 4 5	R L Shoulder	R L Knee	Enthesis	Sens. Def.
R L MCP 1 2 3 4 5	R L A-C	R L Ankle	Cervical	
R L 1st IP	R L S-C	R L TMT 1 2 3 4 5	Thoracic	Neuroclaud.
R L CMC	R L C-C Junc.	R L MTP 1 2 3 4 5	Lumbar	B/Bl Dysf.
R L Wrist	R L TMJ	R L IP Toe 1 2 3 4 5	Sciatica	Sexual Dysf.

Best time of day ____________
Worst time of day ____________

Nocturnal pain No Yes
Functional class I II III IV

___ a.m. stiffness (< ____________)
___ Gelling phenomenon

RHEUMATOLOGY REVIEW OF SYSTEMS

___ Fever
___ Wt loss (___ lb/_____)
___ Lymphadenopathy
___ Fatigue
___ Sleep disturbance
___ Recent infection
___ Recent vaccination
___ New medication
___ Recent travel
___ Unusual pets
___ Rash
___ Photosensitivity
___ K. blennorhagica
___ C. balanitis

___ Alopecia
___ Tick bite
___ Ocular inflammation
___ Xerophthalmia
___ Xerostomia
___ Mucosal ulcers
___ Dysphagia S L
___ GERD
___ IBD
___ Liver disease
___ IBS/IBIS
___ Urethral discharge
___ Venereal disease
___ Kidney disease

___ Kidney stone
___ Sinusitis
___ Pleuritis/pericarditis
___ Persistent cough
___ SOB/DOE
___ Presyncope/syncope
___ Headache
___ Scalp tenderness
___ Visual disturbance
___ Amaurosis fugax
___ Jaw claudication
___ Neck pain
___ Low back pain
___ Radicular symptoms

___ Pseudoclaudication
___ Joint pain
___ Enthesitis
___ Dactylitis
___ RP
___ Skin ulcers
___ Int. claudication
___ Myalgia
___ Weakness
___ Numbness
___ CNS disease
___ Psychiatric disease
___ Stress/anxiety
G___ P___ SAb___ TAb___

RECORDS REVIEW ____________________