Westroads Rheumatology Associates P.C.

Rheumatology Patient Medical History

Date of Appointment: _____
WRA Account Number: _____

Name: _____
First Middle Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Age: _____ Gender: Male ☐ Female ☐
Birthplace: _____ Religion: _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Ethnicity/Race: Hispanic ☐ Asian ☐ Caucasian ☐ African American ☐ American Indian ☐ Other ☐
Language: English ☐ Spanish ☐ American Sign Language ☐ Other_____ ☐

Referring Doctor: _____ Address: _____ Phone: _____
Family Doctor: _____ Address: _____ Phone: _____
Gynecologist: _____ Address: _____ Phone: _____
Orthopedic Surgeon: _____ Address: _____ Phone: _____

PERSONAL AND SOCIAL HISTORY

Do you live alone? Yes ☐ No ☐ If no, who do you live with: _____
Are you presently employed? Yes ☐ No ☐ If no, are you: Retired ☐ Disabled ☐
Present Occupation: _____ Full-Time ☐ Part-Time☐
Past Occupation: _____ Unable to work since: _____
Education: _____
Do you regularly consume alcohol? Never ☐ In the Past ☐ Currently ☐
Average number of drinks per week (now or in the past)? 7 or less (O) ☐ 8-14 (M) ☐ 15 + (H) ☐

How would you describe your cigarette smoking? Never ☐ In the Past ☐ Currently ☐
How many packs per day do you (or did you) smoke? _____ For how many years: _____
Do you use other tobacco products? Specify: _____ Never ☐ In the Past ☐ Currently ☐
Does anybody smoke in the house in which you live? Never ☐ In the Past ☐ Currently ☐

How many caffeinated beverages do you consume per day? 0 ☐ 1-2 ☐ 3-5☐ More than 5☐ Occasional ☐
IV drug use or other recreational drug use? Never ☐ In the Past ☐ Currently ☐
Have you engaged in high risk behavior for sexually transmitted diseases (anal sex, multiple sex partners, same sex)?
Never ☐ In the Past ☐ Currently ☐
Where have you lived (geographically)? _____
Have you recently traveled outside of the US? Yes ☐ No ☐ When/ Where? _____
Have you ever had a Blood Transfusion? Yes ☐ No ☐
Do you have any Body Piercings/ Tattoos? Yes ☐ No ☐ When obtained? _____

How is your appetite? Good ☐ Stable ☐ Poor ☐
Have you been gaining/losing weight? Yes ☐ No ☐ How much? _____
Was the weight change intentional? Yes ☐ No ☐
How much weight change have you experienced? _____ Over how many months? _____
Are you on a special diet? Yes ☐ No ☐ What kind? _____

Exercise Habits: _____
Sports or Hobbies: _____
Military Service: _____

Patient Name: _____

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PATIENT MEDICAL HISTORY

ALLERGIES:

Please list the all allergies that have given you reactions.

If possible, include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath).

No Known Allergies ☐

	Reaction
Anesthesia ☐	
Contrast Allergy ☐	
Iodine Allergy ☐	
Latex Rubber Allergy ☐	
Seasonal Allergy ☐	
Other _____ ☐	
Other _____ ☐	

What **PRESCRIPTION** medications are you taking at this time? (Alternatively bring in an accurate list with you)

Name of Medication	Dosage	Frequency

What **OVER-THE-COUNTER** medications are you taking? (e.g. aspirin, Motrin, Tagament-HB, vitamins, etc.)

Name of Medication	Dosage	Frequency

CANCER

Location/ Type	Year

MEDICATION ALLERGIES:

Please list the all medications that have given you reactions.

If possible, include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath).

No Known Medication Allergies ☐

Name of Medication	Reaction

INJURIES

Fractures	Indicate L or R	Year

Major Accidents	Year

IMMUNIZATIONS

Immunization	Year
H1N1 ☐	
Influenza (Flu) ☐	
Pneumovax (pneumonia) ☐	
Shingles ☐	
TB Skin Test ☐	
Tetanus ☐	
Other _____ ☐	
Other _____ ☐	
Other _____ ☐	

FOR WOMEN ONLY

Number of pregnancies:	
Number of children:	
Boys (list ages):	
Girls (list ages):	
Number of adopted/ stepchildren:	
Number of Miscarriages:	
Date of Last Pap Smear	
Date of Last Mammogram	
Date of Last DEXA	
Form of Contraception:	

Patient Name: _____

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PATIENT MEDICAL HISTORY CONTINUED

SURGERIES (Please mark all surgeries you have had)

	Month/Year		Month/Year
Appendectomy (Appendix) ☐		Transplant (Specify:_____) ☐	
Cholecystectomy (Gallbladder) ☐		Heart (Specify:_____) ☐	
Tonsillectomy ☐		TURP ☐	
Adenoidectomy ☐		Prostatectomy ☐	
Eyes (Specify:_____) ☐		Knee Arthroscopy ☐	
Ears (Specify:_____) ☐		Knee Replacement ☐	
Nose (Specify:_____) ☐		Hip Replacement ☐	
Throat (Specify:_____) ☐		Other Joint Replacement ☐	
Brain Surgery ☐		Shoulder Surgery ☐	
Breast (Specify:_____) ☐		Wrist Surgery ☐	
Colon/ Intestinal ☐		Back Surgery (Specify:_____) ☐	
Hernia Surgery ☐		Joint Fusion ☐	
Weight loss (Bypass/ Banding) ☐		Spinal Fusion ☐	
Heart Valve Replacement ☐		Coronary Artery Bypass Graft ☐	
Hysterectomy (Indicate type of Hysterectomy: Total or Partial / Abdominal or Vaginal) ☐			
Other _____ ☐		Other _____ ☐	
Other _____ ☐		Other _____ ☐	
Other _____ ☐		Other _____ ☐	

OTHER CONDITIONS

	Month/Year		Month/Year
Stroke ☐		Tuberculosis (TB) ☐	
High Blood Pressure ☐		Multiple Sclerosis ☐	
Heart Attack ☐		Arthritis ☐	
Heart Disease ☐		Rheumatoid Arthritis ☐	
High Cholesterol ☐		Osteoarthritis ☐	
Congestive Heart Failure ☐		Psoriatic Arthritis ☐	
Abnormal Heartbeat/ Palpitations ☐		Osteoporosis ☐	
Blood Disease/Bleeding Disorder ☐		Gout ☐	
Anemia ☐		Fibromyalgia ☐	
Blood Clots ☐		Lupus ☐	
Hardening of the Arteries ☐		Kidney Disease ☐	
Treatment with Blood Thinner ☐		Seizure Disorder (Epilepsy) ☐	
Diabetes (Circle: Type I/Type II) ☐		Thyroid Disease ☐	
Asthma ☐		Stomach Ulcer ☐	
Emphysema or COPD ☐		Cancer (Specify:_____) ☐	
Hepatitis (Circle: Type B/Type C) ☐		Depression ☐	
Exposure to/Positive for HIV ☐		Antibiotic Treatment (past 2 mon.) ☐	
Other _____ ☐		Other _____ ☐	
Other _____ ☐		Other _____ ☐	
Other _____ ☐		Other _____ ☐	

Patient Name: _____

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FAMILY HISTORY

	Age	Health			Age at Death	Cause of Death
Father		Good ☐	Stable ☐	Poor ☐		
Mother		Good ☐	Stable ☐	Poor ☐		
Brothers:		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
Sisters:		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
Maternal Grandfather		Good ☐	Stable ☐	Poor ☐		
Maternal Grandmother		Good ☐	Stable ☐	Poor ☐		
Paternal Grandfather		Good ☐	Stable ☐	Poor ☐		
Paternal Grandmother		Good ☐	Stable ☐	Poor ☐		
Spouse		Good ☐	Stable ☐	Poor ☐		
Sons:		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
Daughters:		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		
		Good ☐	Stable ☐	Poor ☐		

Please list all family members effected by the following:

Family History Unknown ☐ *Adopted ☐*

M = Mother MGM = Maternal Grandmother MGF = Maternal Grandfather F = Father
PGM = Paternal Grandmother PGF = Paternal Grandfather B = Brother S = Sister O = Other immediate family

Alcohol Abuse		Hepatitis B	
Bleeding Disorder		Hepatitis C	
Blood Clots		Hypertension	
Cancer, Breast		Irritable Bowel Syndrome	
Cancer, Ovarian		Kidney Disease	
Cancer, Lung		Mental Illness	
Cancer, Prostate		Osteoporosis	
Cancer, Stomach		Osteoarthritis	
Cancer, Uterine		Other Arthritis (Please specify)	
Cancer, Colon		Pancreatitis	
Cancer, Other		Rheumatoid Arthritis	
Crohn's Disease		Seizure Disorders	
Diabetes		Sickle Cell	
Liver Disease		Stroke	
Gallstones		Thyroid	
Gout		Tuberculosis (TB)	
Heart Attack		Ulcer Disease	
Heart Disease		Ulcerative Colitis	
Other _____		Other _____	
Other _____		Other _____	

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RHEUMATIC DISEASE EVALUATION

Briefly describe your present symptoms: _____

When did you first notice your symptoms? _____

Do you have morning stiffness? _____ When did it begin? _____ How long does it last each day? _____

Do you become unusually fatigued during the day? _____ Every day? _____ At what time? _____

Does sunlight bother you or cause a rash? _____

Have you had any hair loss with these symptoms? _____

Do your hands turn blue/ white in cold weather? _____ Do you have dry eyes? _____ Dry mouth? _____

Please list the joints that have been involved: _____

Have you had joint injections? _____ Which joints? _____

Have you ever had a blood transfusion? _____ Have you had physical therapy? _____

List physicians, podiatrists, or chiropractors you have seen for arthritis and the approximate date of these evaluations:

Have you taken any of the following drugs?

- Circle the ones you have taken
- Check the following code boxes accordingly

Codes: E = Effective
I = Ineffective
SE = Side Effects / Adverse Effects

	E	I	SE		E	I	SE		E	I	SE
Analgesics – NSAIDs				**Disease Modifiers (DMARDS)**				**Corticosteroids**			
Ansaid, flurbiprofen				Arava, leflunomide				Prednisone,			
Aspirin				Azulfidine, sulfasalazine				Medrol, methylprednisolone			
Bextra, valdecoxib				Cytoxan, cyclophosphamide				**Other Rheumatologics**			
Celebrex, celecoxib				Gold (injection, pills)				Hyalgan, Supartz, hyaluronate			
Clinoril, sulindac				Imuran, azathioprine				Orthovisc, hyaluronan			
Daypro, oxaprozin				Dynacin, Minocin, minocycline				Synvisc, hylan GF 20			
Dolobid, diflunisal				Plaquenil, hydroxychloroquine				**Osteoporosis/ Osteopenia**			
Feldene, piroxicam				Rheumatrex, methotrexate				Actonel, risedronate			
Indocin, indomethacin				**Biologics**				Boniva, ibandronate			
Lodine, etodolac				Cimzia, certolizumab				Evista, raloxifene			
Mobic, meloxicam				Enbrel, etanercept				Forteo, teriparatide			
Motrin, Advil, ibuprofen				Humira, adalumumab				Fosamax, alendronate			
Naprosyn, Aleve, naproxen				Kineret, anakinra				Miacalcin, calcitonin			
Relafen, nabumetone				Orencia, abatacept				Reclast, zoledronic acid			
Tolectin, tolmetin				Remicade, infliximab				**Hormones**			
Voltaren, arthrotec, diclofenac				Rituxan, rituximab				Estrogen, progesterone			
Vioxx, rofecoxib				Simponi, golimumab				testosterone			
Analgesics – Narcotics				**Gout**				**Muscle Relaxants**			
Darvon, Darvocet, propoxyphene				Colchicine				Flexeril, cyclobenzaprine			
Demerol, meperidine				Probenicid				Norflex, orphenadrine			
Dilaudid, hydromorphone				Uloric, febuxostat				Skelaxin, metaxalone			
Duragesic, fentanyl				Zyloprim, allopurinol				Soma, carisoprodol			
Vicodin, Lortab, Lorcet, hydrocodone				**Other Neurologics**				Zanaflex, tizanidine			
MS Contin, morphine				Provigil, modafinil				**Sjögren's Syndrome**			
OxyContin, Percocet, oxycodone				**Antidepressants**				Evoxac, cevimeline			
Tylenol #2, #3, #4, codeine				Cymbalta, duloxetine				Lacrisert, hydroxypropyl cellulose			
Analgesics - Other				Desyrel, trazodone				Restasis, cyclosporine			
Tylenol, acetaminophen				Effexor, venlafaxine				Salagen, pilocarpine HCI			
Ultram, Ultracet, tramadol				Elavil, amitriptylene				**Anti-Parkinsonians**			
Zostrix, capsaicin cream				Lexapro, escitalopram				Mirapex, pramipexole			
Anti-convulsants				Lyrica, pregabalin				Sinemet, carbidopa/levodopa			
Neurontin, gabapentin				Pamelor, nortriptylene				**Immunosuppressants**			
Topamax, topiramate				Pristiq, desvenlafaxine				CellCept, mycophenolate mofetil			
				Prozac, fluoxetine				Neoral, cyclosporine			

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FUNCTIONAL EVALUATION:
MODIFIED HEALTH ASSESSMENT QUESTIONAIRE (mHAQ)

mHAQ scoring (office use only)

Formula: Total score = number of answered questions = mHAQ

Please mark the one response that best describes your usual abilities over the past few days:	Without ANY Difficulty (0)	With SOME Difficulty (1)	With MUCH Difficulty (2)	UNABLE to do (3)
1) Dress yourself, including tying shoelaces and fastening buttons?				
2) Get in and out of bed?				
3) Lift a full cup/glass to your mouth?				
4) Walk outdoors on flat ground?				
5) Wash and dry your entire body?				
6) Bend down and pick up clothing from the floor?				
7) Turn water faucets on and off?				
8) Get in and out of the car?				

On a scale of 1-10, how would you rate your PAIN?

None |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Severe
0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how would you rate your FATIGUE?

None |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Severe
0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how would you rate your DISEASE ACTIVITY?

None |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Severe
0 1 2 3 4 5 6 7 8 9 10

Circle either YES or NO			**PLEASE DO NOT WRITE IN SPACE BELOW**
YES	NO	Have you had fever or chills recently?	GNL
YES	NO	Do you have frequent headaches?	
YES	NO	Have you ever had a convulsion, fit, or epilepsy?	
YES	NO	Have you had a rash or other skin problems?	INT
YES	NO	Have you had red or inflamed eyes?	EENT
YES	NO	Have you had pain or ringing in your ears?	
YES	NO	Do you have trouble swallowing?	
YES	NO	Have you ever had shortness of breath?	RES
YES	NO	Do you have a chronic cough?	
YES	NO	Have you ever had chest pain or tightness in your chest?	CV
YES	NO	Have you had a heart attack? (In what year(s):_____)	
YES	NO	Do you frequently have stomach upsets?	GI
YES	NO	Have you had any recent changes in your bowel habits?	
YES	NO	Have you ever had an ulcer? (In what year(s):_____)	
YES	NO	Have you had intestinal bleeding, black, or tarry stools?	
YES	NO	Have you had recent frequency or burning with urination?	GU
YES	NO	Do you get up frequently at night to urinate? (How many times? _____)	
YES	NO	Have you ever passed a kidney stone? (In what year(s):_____)	
YES	NO	Are you more sensitive to cold exposure than others in the same area?	END
YES	NO	Have you been nervous or depressed? (circle if applicable)	PSY
To be answered by WOMEN ONLY:			GYN
YES	NO	Has there been a change in frequency or amount of your menstrual flow?	
Date of last period? _____			
Date of last pap smear (cancer test)? _____			
Date of last DEXA or Osteoporosis screening? _____			
Number of pregnancies? _____			
Number of children born alive? _____			