CENTER FOR RHEUMATOLOGY

Solutions for diseases of joints, muscles, bones and arthritis

HEALTH HISTORY

(Confidential)

Name ____________________ Birthdate ____________ Age _______ Date ____________

Date of last physical examination ____________What is your reason for the visit ______________________

SYMPTOMS: Check (ç) symptoms you currently have or have had in the past year

General
- ☐Chills
- ☐Depression
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headache
- ☐Loss of Sleep
- ☐Loss of Weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

Muscle/Joint/Bone
- ☐Arms ☐Hips
- ☐Back ☐Legs
- ☐Feet ☐Neck
- ☐Hands ☐Shoulders

Genito-Urinary
- ☐Blood in Urine
- ☐Frequent Urination
- ☐Lack of Bladder
- ☐Control
- ☐Painful Urination

Gastrointestinal
- ☐Poor Appetite
- ☐Bloating
- ☐Bowel Changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal Bleeding
- ☐Stomach Pain
- ☐Vomiting
- ☐Vomiting Blood

Cardiovascular
- ☐Chest Pain
- ☐High Blood Pressure
- ☐Irregular Heart Beat
- ☐Low Blood Pressure
- ☐Poor Circulation
- ☐Rapid Heart Beat
- ☐Swelling of Ankles
- ☐Varicose Veins

Eye, Ear, Nose & Throat
- ☐Bleeding Gums
- ☐Blurred Vision
- ☐Crossed Eyes
- ☐Difficulty Swallowing
- ☐Double Vision
- ☐Earache
- ☐Ear Discharge
- ☐Hay Fever
- ☐Hoarseness
- ☐Loss of Hearing
- ☐Nosebleed
- ☐Persistent Cough
- ☐Ringing in ears
- ☐Sinus Problems
- ☐Vision-Flashes
- ☐Vision-Halos

Skin
- ☐Bruise Easily
- ☐Hives
- ☐Itching
- ☐Change in Moles
- ☐Rash
- ☐Scars
- ☐Sore(s) that wonøt heal

Men Only
- ☐Breast Lump
- ☐Erection Difficulties
- ☐Lump in Testicles
- ☐Penis Discharge
- ☐Sore(s) on Penis
- ☐Other:____________

Women Only
- ☐Abnormal Pap Smear
- ☐Bleeding between periods
- ☐Breast Lump
- ☐Extreme Menstrual Pain
- ☐Hot Flashes
- ☐Nipple Discharge
- ☐Painful Intercourse
- ☐Vaginal Discharge
- ☐Other: ____________

Date of last Menstrual period:____________

Date of last Pap Smear: ____________

Have you had a Mammogram? ____________

Are you pregnant? ____________

Number of Children: ____________

CONDITIONS: Check (ç) conditions you have or have had in the past.

AIDS	Cancer	Heart Disease	Mononucleosis	Suicide Attempt
Alcoholism	Cataracts	Hepatitis	Multiple Sclerosis	Thyroid Problems
Anemia	Chemical Dependency	Hernia	Mumps	Tonsillitis
Anorexia	Chicken Pox	Herpes	Pacemaker	Tuberculosis
Appendicitis	Diabetes	High Cholesterol	Pneumonia	Typhoid Fever
Arthritis	Emphysema	HIV Positive	Polio	Ulcers
Asthma	Epilepsy	Kidney Disease	Prostrate Problem	Vaginal Infections
Bleeding Disorders	Glaucoma	Liver Disease	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Measles	Rheumatic Fever	
Bronchitis	Gonorrhea	Migraine Headaches	Scarlet Fever	
Bulimia	Gout	Miscarriage	Stroke	

MEDICATIONS: List medications you are currently taking			**ALLERGIES:** Medications or substances
Pharmacy Name:		Phone Number:	

FAMILY HISTORY: Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (ç) if, your blood relatives had any of the following:		
Father					Disease		Relationship to you
Mother						Arthritis/Gout	
Brother (s)						Asthma/Hay Fever	
						Cancer	
						Chemical Dependency	
						Diabetes	
Sister (s)						Heart Disease/Stroke	
						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other:	

HOSPITALIZATIONS/SURGERIES:			**Pregnancy History:**		
Year Outcome	Hospital	Reason for Hosp./Surgery	Year of Birth	Sex of Birth	Complications if any:

HEALTH HABITS: Check (ç) which substances you use and describe how much you use

(ç)	**Substance**	**Quantity/Frequency**
	Caffeine	
	Tobacco	
	Drugs	
	Other:	

OCCUPATIONAL CONCERNS: Check (ç) if your work exposes you to the following

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
Your Occupation:	

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates:

Serious Injury	**Date**	**Outcome**

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature ____________________ Date ____________________

Reviewed by ____________________ Date ____________________