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Form Revised 2/6/19

AOC Arthritis & Osteoporosis Center

New Patient History Form

Today's Date: _____

Name: _____ Birthdate: _____
(Last) (First) (MI) (Maiden) (MM/DD/YYYY)

Address: _____ Age: _____ Sex: ☐F ☐M
Street Apt#

_____
City State Zip

MARITAL STATUS: ☐ Never Married ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse/Significant Other: Name _____

EDUCATION (Circle highest level attended): Grade School 7 8 9 10 11 12 College 1 2 3 4 ☐Graduate School

Occupation _____ Number of hours worked/average per week _____

Employer _____

Referred here by: (check one) ☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional

Name of person making referral: _____ Primary Care Physician: _____

Are you on disability? Y☐ N☐ Applying/or planning to apply for disability? Y☐ N☐

Are you currently or have you been involved in a medically related lawsuit? Y☐ N☐

Describe briefly your present symptoms: _____

_____

_____

Date symptoms began (approximate): _____ Diagnosis: _____

Previous treatment for this problem (includes physical therapy, surgery and injections; medications to be listed later): _____

_____

_____

Please list the names of other doctors (Rheumatologist) you have seen for this problem: _____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative/Relationship	Yourself		Relative/Relationship
	Arthritis (unknown type)			Lupus or SLE	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient Name _____ DOB: _____

SYSTEM REVIEW

Date of last chest x-ray _____ Date of last Tuberculosis Test _____ Date of last bone densitometry _____

As you review the following list, please check any of these problems which have significantly affected you.

Constitutional
☐ Fatigue
☐ Fever
☐ Chills
☐ Night Sweats
☐ Hot flashes
☐ Recent weight loss amount_____
☐ Recent weight gain amount_____

Eyes-Ears-Nose-Mouth-Throat
☐ Dry eyes
☐ Itchy eyes
☐ Eye pain
☐ Eye Inflammation
☐ Vision changes
☐ Blurred vision
☐ Double vision
☐ Dry mouth
☐ Mouth sores
☐ Mouth ulcers
☐ Excessive dental decay
☐ Hoarseness
☐ Sinus Problems
☐ Runny nose
☐ Parotid Swelling
☐ Hearing loss
☐ Ringing in ears

Respiratory
☐ Chronic cough
☐ Cough
☐ Shortness of breath at rest
☐ Shortness of breath with activity
☐ Difficulty breathing at night
☐ Pleurisy
☐ Coughing up blood
☐ Wheezing (asthma)

Cardiovascular
☐ Chest pain
☐ Chest pressure
☐ Swollen legs or feet (edema)
☐ Irregular heartbeat
☐ Heart palpitations
☐ Color changes of hands or feet in cold

Endocrine
☐ Excessive hair loss
☐ Male pattern hair loss
☐ Excessive thirst

Gastrointestinal
☐ Stomach pain
☐ Difficulty swallowing
☐ Vomiting of blood or coffee ground material
☐ Blood in stools
☐ Black stools
☐ Constipation
☐ Persistent diarrhea
☐ Heartburn
☐ Reflux
☐ Nausea
☐ Decreased appetite

Genitourinary
☐ Cloudy, "smoky" urine
☐ Pain or burning on urination
☐ Blood in urine
☐ Getting up at night to pass urine
☐ Rash/ulcers
☐ Abnormal discharge from penis/vagina

For Women Only:
Periods regular? Y☐ N☐
Date of last period? _____
Number of pregnancies? _____
Number of miscarriages? _____

Neurological System
☐ Dizziness
☐ Lightheadedness
☐ Vertigo
☐ Numbness
☐ Tingling
☐ Headaches
☐ Jaw cramping when chewing
☐ Scalp tenderness
☐ Memory Loss
☐ Seizures

Psychiatric
☐ Anxiety
☐ Depression
☐ Suicidal thoughts

☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Wake up tired in morning

Skin
☐ Hives
☐ Rash
☐ Sun sensitive (sun allergy)
☐ Psoriasis
☐ Nodules
☐ Tightness/thickening

Musculoskeletal
☐ Back pain
☐ Neck pain
☐ Joint pain
☐ Joint swelling
☐ Muscle pain
☐ Muscle tenderness
☐ Muscle weakness
☐ Morning stiffness lasting how long?
mins hours

List joints affected in the last 6 months

Any previous fractures? Y☐ N☐
Which bone/cause of fracture:

☐ Height loss
What was your tallest height ever?
FT_____ IN_____
Any other serious injuries? Y☐ N☐
Please describe:

Hematologic/Lymphatic
☐ Easy bruising
☐ Easy bleeding
☐ Blood clots
☐ Anemia
☐ Swollen glands

Allergic/Immunologic
☐ Frequent sneezing

☐ Environmental allergies
☐ Food allergies
☐ Seasonal allergies
☐ Frequent infections
☐Recent infection

Patient Name _____ DOB: _____

Social History

Do you drink caffeinated beverages? Y☐ N☐

Cups/glasses per day? _____

Do you smoke? Y☐ N☐ Previous smoker? Y☐ N☐

When did you stop? _____

Do you drink alcohol? Y☐ N☐ Number per week_____

Has anyone ever told you to cut down on your drinking?

Y☐ N☐

Do you use drugs for reasons that are not medical?

Y☐ N☐

If yes, please list _____

_____

Do you exercise regularly? Y☐ N☐

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Y☐ N☐

Do you wake up feeling rested? Y☐ N☐

Past Medical History

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

☐ Cancer	☐ Heart Problems	☐ Asthma
☐ Thyroid Problems	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy/Seizures
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Migraine	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Kidney stones	☐ HIV/AIDS	☐ High Blood Pressure
☐ Anemia	☐ Glaucoma	☐ Tuberculosis
☐ Emphysema	☐ Irritable Bowel Syndrome	
☐ Heart Murmur	☐ Prostate problems	

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, etc.) _____

_____

_____

_____

Previous Operations

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

Family History

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause of Death
Father				
Mother				

Number of siblings_____ Number living_____ Number deceased_____

Number of children: Male_____ Female_____ Number living_____ Number deceased_____

Health of children: _____

_____

Do you know of any blood relative who has or had the following problems? (Check and list relationship to you.)

☐ Cancer	_____	☐ Heart Disease	_____	☐ Epilepsy	_____
☐ Leukemia	_____	☐ High Blood Pressure	_____	☐ Asthma	_____
☐ Stroke	_____	☐ Bleeding Tendency	_____	☐ Psoriasis	_____
☐ Colitis	_____	☐ Alcoholism	_____	☐ Thyroid Disease	_____
☐ Tuberculosis	_____	☐ Diabetes	_____		

MEDICATIONS

Drug allergies: Y☐ N☐ Drug Name / Reaction _____

_____

_____

CURRENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxative, calcium and other supplements, etc)

Name of Drug	DOSE (How many mg? How many pills per day?)	What date did you start this medication?	Does it help? A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

PAST MEDICATIONS (Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comment in the spaces provided.)

Drug names/Dosage	Year - Start/Stop	Did it Help? A Lot	Some	Not at All	Reactions
Pain Relievers					
Acetaminophen (Tylenol)					
Codeine (Vicodin, Tylenol 3)					
Ultram (Tramadol/ultracet)					
Other:					
Disease Modifying Antirheumatic Drugs (DMARDS)					
Ridaura (Auranofin, gold pills)					
Gold shots (Myochrysine or Solganol)					
Plaquenil (Hydroxychloroquine)					
Penicillamine (Cuprimine or Depen)					
Methotrexate (Rheumatrex)					
Imuran (Azathioprine)					
Sulfasalazine (Azulfidine)					
Arava (Leflunomide)					
Cytoxan (Cyclophosphamide)					
Cyclosporine A (Sandimmune or Neoral)					
Enbrel (Etanercept)					
Remicade (Infliximab)					
Humira (Adalimumab)					
Simponi (Golimumab)					
Cimzia (Certolizumab)					
Orencia (Abatacept)					
Actemra (Tocilizumab)					
Rituxan (Rituximab)					
Other:					
Other:					

Patient Name _____ DOB: _____

PAST MEDICATIONS Continued…

Drug names/Dosage	Year - Start/Stop	Did it Help? A Lot	Some	Not at All	Reactions
Osteoporosis Medications					
Estrogen (Premarin, etc.)					
Fosamax (Alendronate)					
Actonel (Risedronate)					
Forteo (Teriparatide)					
Evista (Raloxifene)					
Calcitonin injections or nasal (Miacalcin, Calcimar)					
Boniva (Ibandronate)					
Reclast (Zoledronic Acid)					
Prolia (Denosumab)					
Other:					
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS)					
Ansaid (ibuprofen)					
Arthrotec (diclofenac + misoprostol)					
Aspirin (including coated aspirin)					
Celebrex (celecoxib)					
Daypro (oxaprozin)					
Disalcid (salsalate)					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Indocin (indomethacin)					
Lodine (etodolac)					
Mobic (Meloxicam)					
Motrin/Rufen (ibuprofen)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Relafen (nabumetone)					
Tolectin (tolmetin)					
Vimovo (Naproxen + esomeprazole)					
Voltaren (diclofenac)					
Other:					
Gout Medications					
Probenecid (Benemid)					
Colchicine					
Allopurinol (Zyloprim/Lopurin)					
Febuxostat (Uloric)					
Other:					
Others					
Tamoxifen (Nolvadex)					
Cortisone/Prednisone/Medrol					
Hyalgan/Synvisc/Supartz/Euflexxa injections					
Herbal or Nutritional Supplements					
Please list supplements:					

All 5 pages completed by: _____ Relationship: Patient Spouse Parent Other

Print Name

_____ Date: _____

Signature