



BW Arthritis & Rheumatology

Healthy Joints, Healthy Bones

Patient History Form

Date: ____/____/____ Email Address: _____

Name: _____
Last (First)

Birthdate: ____/____/____ Age: ____ Sex: F M

Name of Primary Care Physician: _____

Name of Referring Physician: _____

Occupation: _____

Why are you here today (your main complaint) _____

When did symptoms start _____

What diagnosis have you been given? _____

Previous treatment for this problem (Physical Therapy Surgery, or Injections)? _____

Medications and Supplements (Please list all medications both prescribed and over the counter that you are now taking i.e Aspirin, Vitamins, Glucosamine, Laxatives, Calcium, Etc.)

Name Of Drug Dose	Dose and Number of Pills Per Day
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

Drug Allergies: No, If yes what medications? _____



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Past Medical History: _____

Previous Operations:

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

Family History:

Relationship	Age	Health	Age of Death	Cause
Father				
Mother				

Children: Y N

Social History:

- Do you smoke? Y or N

In The Past? _____ How Long Ago: _____

- Do you drink alcohol? Y or N

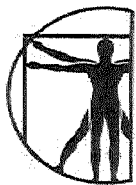
If yes, Socially or Daily

- Do you use drugs for reasons that are not medical? Y or N

If yes, please list: _____

Immunization History:

Flu Shot	
Pneumonia Shot	
Zoster/Shingle Shot	



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SYSTEMS REVIEW

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

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ☐ Recent weight gain
amount _____
- ☐ Recent weight loss
amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

- Age when periods began: _____
- Periods regular? ☐ Yes ☐ No
- How many days apart? _____
- Date of last period? ____/____/____
- Date of last pap? ____/____/____
- Bleeding after menopause? ☐ Yes ☐ No
- Number of pregnancies? _____
- Number of miscarriages? _____

Musculoskeletal

- ☐ Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine

- ☐ Excessive thirst

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection