



JOHNS HOPKINS M E D I C I N E

RHEUMATOLOGY PATIENT HISTORY FORM

Date: ____/____/____

NAME: _____ Birthdate: ____/____/____
Last First M. I.

Age: _____ Sex: F M

Marital status: Never married Married Divorced Separated Widowed Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any? _____

Please list the names of other practitioners you have seen for this problem: _____

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

Please shade all the locations of your pain over the past week on the body figures and hands.
Example:

The diagram shows four body figures and two hand diagrams. The first figure is a front view of a male torso with shaded areas on the right shoulder and right knee. The second figure is a back view of a male torso with a shaded area on the spine. The third figure is a back view of a female torso with a shaded area on the spine. The fourth figure is a front view of a female torso with shaded areas on both wrists. Below the figures are two hand diagrams, labeled 'Left' and 'Right', with shaded areas on the fingers and palms. To the right of the hand diagrams is the text: 'Are you ____ right or ____ left handed? (Which hand do you sign your name with?)'

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Lupus or "SLE"	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Childhood arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____
Psoriasis/psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	→	_____

PAST MEDICAL HISTORY

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other significant illnesses (please list): _____

Previous Operations

Type	Year	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Any previous fractures? No Yes Describe _____

Any other serious injuries? No Yes Describe _____

Do you smoke? Yes No In the past - How long ago? _____

Do you drink alcohol? No Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? Yes No

Do you use drugs for reasons that are not medical? No Yes If yes, please list: _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

MEDICATIONS

Drug allergies: No Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug **Dose (include strength and number of pills per day)**

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

PERSONAL HISTORY

What is your highest educational level? High school Some college courses College graduate Advanced degree

What is your current or past occupation? _____

Are you currently working? : Yes No If yes, hours/week _____ If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

SYSTEMS REVIEW

Date of last eye exam _____

Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: Never done Negative Positive

Date test performed: _____

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats

MUSCLE/JOINTS/BONES

- Morning stiffness
Lasting how long _____ Minutes
_____ Hours
- Joint pain
- Muscle weakness
- Joint swelling
- List joints affected in the last 6 months

EARS

- Ringing in ears
- Loss of hearing

EYES

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

MOUTH

- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness
- Recent increase in tooth cavities

NOSE

- Nosebleeds
- Loss of smell

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw while chewing

NECK

- Swollen glands
- Tender glands

HEART AND LUNGS

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain relieved by food
- Vomiting of blood/"coffee grounds"
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

KIDNEY/URINE/BLADDER

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

BLOOD

- Anemia
- Bleeding tendency

SKIN

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive
- Skin tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling in hands/feet
- Memory loss
- Muscle weakness

PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

No Yes If yes, at what age: _____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? Yes No

How many days apart? _____