Rheumatology Center of Princeton

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INITIAL PATIENT HISTORY AND HEALTH ASSESMENTS

Please take a few minutes to fill out the information on all six pages as completely as you can. Any information you can give on this form will help in our care for you; if you cannot fill out a section, please skip it and move on. Thank you.

PERSONAL HISTORY:

Marital Status: ☐ Minor ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Significate Other: ☐ Alive / Age: ____ ☐ Deceased / Age: ____ Major Illnesses: ____________________

Education: Grade School ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 College ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Graduate School

Employment: ☐ F/T ☐ P/T ☐ Student ☐ Homemaker ☐ Retired ☐ Disabled ☐ Unemployed ☐ Other

Occupation ____________________________________ **Number of Hours Worked / Average per Week** __________

Referred here by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional ☐ Other

Name of Referral Source: ____

Name of your Primary Care Provider: ____

Do You Have an Orthopedic Surgeon? ☐ Yes ☐ No If Yes, Name: ___________________________________

SOCIAL HISTORY:

Do you drink caffeinated beverages ☐ Yes ☐ No If Yes, Cups / Glasses per day: ____________________

Do you smoke? ☐ Never ☐ Yes: Packs / Day: _____ # Years: _____ Past: How Long Ago? _____

Do you drink alcohol? ☐ Yes: Number of Drinks per Week: _____ ☐ No

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

Do you exercise regularly? ☐ Yes ☐ No Type: _____________________ Amount per Week: __________

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

Do you get enough sleep at night? ☐ Yes ☐ No Do you wake up feeling rested? ☐ Yes ☐ No

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				

Number of siblings: ______ Number Living: _____ Number Deceased: _____

Number of Children: ______ Number Living: _____ Number Deceased: _____

List age / health of each child: ____

Do you know of any blood relative who has or had ….. (check and give relationship)

☐ Gout __________________ ☐ Epilepsy ________________ ☐ Tuberculosis ______________

☐ Goiter __________________ ☐ Asthma ________________ ☐ Diabetes ________________

☐ Stroke __________________ ☐ Psoriasis ________________ ☐ Leukemia ________________

☐ Colitis __________________ ☐ Cancer ________________ ☐ Alcoholism ________________

Name: ____ Date: _______________ Age: __________ Sex: ☐ M ☐ F

MEDICAL HISTORY:
As you review the following list, please check any items which have significantly affected you.

CONSTITUTIONAL
- ☐ Recent weight gain
  Amount: __________
- ☐ Recent weight loss
  Amount: __________
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

SKIN AND /OR BREAST
- ☐ Easy Bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun Sensitivity (sun allergy)
- ☐ Tightness
- ☐ Nodules / Bumps
- ☐ Hair Loss
- ☐ Color changes of hand or feet in cold

ALLERGIC /IMMUNOLOGIC
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

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

ENDOCRINE
- ☐ Excessive thirst

HEMATOLOGIC/LYMPHATIC
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion
  When: ____________

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

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

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting of blood or "coffee grounds" 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 urinate
- ☐ Vaginal dryness
- ☐ Rash / Ulcers
- ☐ Sexual difficulties
- ☐ Prostate Trouble

NEUROLOGICAL SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle Spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain in hands/feet
- ☐ Memory loss
- ☐ Night sweats

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

MUSCULOSKELETAL
- ☐ Morning stiffness
  How long? ________

JOINT PAIN
- ☐ Muscle weakness
- ☐ Joint swelling
  List Joints Affected
  ____
  ____
  ____
  ____
  ____

FOR WOMEN ONLY

Age when periods began: ___________________________
How many days apart: ______________________________
Date of last pap: __________________________________
Number of pregnancies: ____________________________
Contraceptive Method: _____________________________

Periods regular? ☐ Yes ☐ No
Date of last period: _____________________
Bleeding after menopause ☐ Yes ☐ No
Number of miscarriages: ______________

PAST MEDICAL HISTORY: Do you now have, or have you ever had (Check if Yes)

☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pneumonia
☐ Asthmas	☐ Emphysema	☐ HIV / AIDS	☐ Psoriasis
☐ Bad Headaches	☐ Epilepsy	☐ Jaundice	☐ Rheumatic Fever
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Stomach Ulcers
☐ Cataracts	☐ Goiter	☐ Leukemia	☐ Stroke
☐ Colitis	☐ Heart Problems	☐ Nervous Breakdown	☐ Tuberculosis

Other Significant Illnesses (Please List):

Name: ____ Date: _______________ Age: __________ Sex: ☐ M ☐ F

PAST SURGICAL HISTORY: Operations you have had:

	TYPE	Year	Reason
1			
2			
3			
4			
5			

Any previous fractures? ☐ No ☐ Yes Describe: ____

Any other serious injuries? ☐ No ☐ Yes Describe: ____

Date of last Eye Exam: ______________________________ Date of last Chest X-ray: ______________________________

Date of last Bone Densitometry: ______________________ Date of last Tuberculosis test: __________________________

Date of last Mammogram: ___________________________ Date of last Pap Smear / PSA: ___________________________

MEDICATIONS: Please list any medications you are currently takin, INCLUDING such items as aspirin, vitamins, laxative, calcium, herbal supplement, etc.

	Name of Drug	**Dose (Include Strength & number of pills per day)**	**How long have you taken this medication?**	**Please Check: HELPED?**		
1				☐ **A lot**	☐ **Some**	☐ **No**
2				☐ **A lot**	☐ **Some**	☐ **No**
3				☐ **A lot**	☐ **Some**	☐ **No**
4				☐ **A lot**	☐ **Some**	☐ **No**
5				☐ **A lot**	☐ **Some**	☐ **No**
6				☐ **A lot**	☐ **Some**	☐ **No**
7				☐ **A lot**	☐ **Some**	☐ **No**
8				☐ **A lot**	☐ **Some**	☐ **No**
9				☐ **A lot**	☐ **Some**	☐ **No**
10				☐ **A lot**	☐ **Some**	☐ **No**

Drug Allergies: ☐ NONE ☐ Yes To what? ____

CURRENT MEDICAL HISTORY:

Please describe briefly your present symptoms. (In other words, what brings you to us today?)

About when did these symptoms begin?

Name: ______________________________ Date: ____________ Age: __________ Sex: ☐ M ☐ F

CURRENT MEDICAL HISTORY (Continued)

Have you been given a diagnosis for these symptoms? ☐ No ☐ Yes ____

Have you been previously treated for this problem? ☐ No ☐ Yes

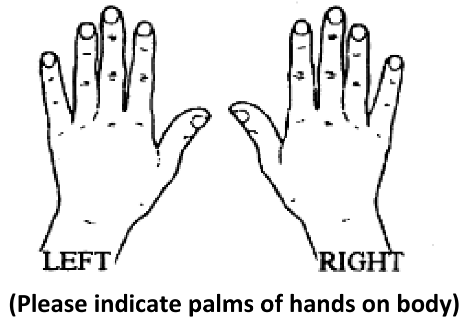
What kind of treatment? ☐ Medication ☐ Physical Therapy ☐ Injection ☐ Surgery
☐ Other ____

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

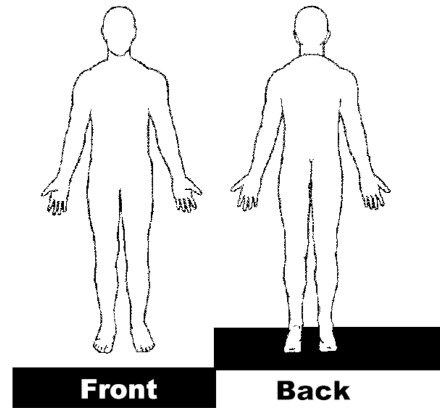
____

Please indicate all area you have had pain over the past week on the body figures and hands.

XXXXX = PAIN . . . . = BURNING - - - - - - - - - - = TINGLING



(Please indicate palms of hands on body)



RHEUMATOLOGIC / ARTHRITIS HISTORY

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

			Relationship				Relationship
Arthritis (unknown type)	☐ Self	☐ Relative		**Lupus or "SLE"**	☐ Self	☐ Relative	
Osteoarthritis	☐ Self	☐ Relative		**Rheumatoid Arthritis**	☐ Self	☐ Relative	
Gout	☐ Self	☐ Relative		**Ankylosing Spondylitis**	☐ Self	☐ Relative	
Childhood Arthritis	☐ Self	☐ Relative		**Osteoporosis**	☐ Self	☐ Relative	
Other Arthritis	☐ Self	☐ Relative		**Other Arthritis**	☐ Self	☐ Relative	

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.

Drug Names / Dosage	Length of Time	Please Check: Helped?			Reactions / Comments
NSAIDS					
Ansaid (flurbiprofen)		☐ A lot	☐ Some	☐ No	
Arthrotec (Diclofenac&Misoprostol)		☐ A lot	☐ Some	☐ No	
Aspirin (Including coated aspirin)		☐ A lot	☐ Some	☐ No	
Celebrex (Celecoxib)		☐ A lot	☐ Some	☐ No	
Clinoril (Sulindac)		☐ A lot	☐ Some	☐ No	
Daypro (Oxaprozin)		☐ A lot	☐ Some	☐ No	
Disalcid (Salsalate)		☐ A lot	☐ Some	☐ No	
Dolobid (Diflunisal)		☐ A lot	☐ Some	☐ No	
Feldene (Piroxicam)		☐ A lot	☐ Some	☐ No	
Indocin (Indomethacin)		☐ A lot	☐ Some	☐ No	
Lodine (Etodolac)		☐ A lot	☐ Some	☐ No	
Meclomen (Meclofenamate)		☐ A lot	☐ Some	☐ No	
Motrin/Advil/Rufen (Ibuprofen)		☐ A lot	☐ Some	☐ No	

Name: ________________________________ Date: ______________ Age: __________ Sex: ☐ M ☐ F

Drug Names / Dosage	Length of Time	Please Check: Helped?			Reactions / Comments
NSAIDS (Continued)					
Oruvail/Orudis (Ketoprofen)		☐ A lot	☐ Some	☐ No	
Tolectin (Tolmetin)		☐ A lot	☐ Some	☐ No	
Trilisate (Choline Magnesium Trisallcylate)		☐ A lot	☐ Some	☐ No	
Vioxx (Rofecoxib)		☐ A lot	☐ Some	☐ No	
Voltaren (Difofenac)		☐ A lot	☐ Some	☐ No	
PAIN RELIEVERS					
Acetaminophen (Tylenol)		☐ A lot	☐ Some	☐ No	
Codeine (Vicodin, Tylenol #3)		☐ A lot	☐ Some	☐ No	
Propoxphene (Darvon/Darvocet)		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
DISEASE MODIFYING ANTI-RHEUMATIC DRUG (DMARDs)					
Auranofin, Gold pill (Ridaura)		☐ A lot	☐ Some	☐ No	
Gold shots (Myochrysine or Golganol)		☐ A lot	☐ Some	☐ No	
Hydroxychloroquine (Plaquenil)		☐ A lot	☐ Some	☐ No	
Penicillamine (Cuprimine or Depen)		☐ A lot	☐ Some	☐ No	
Methotrexate (Rheumatrex)		☐ A lot	☐ Some	☐ No	
Azathioprine (Imuran)		☐ A lot	☐ Some	☐ No	
Sulfasalzine (Azulfidine)		☐ A lot	☐ Some	☐ No	
Quinacrine (Atabrine)		☐ A lot	☐ Some	☐ No	
Cycolophosphamide (Cytoxan)		☐ A lot	☐ Some	☐ No	
Cyclosporine A (Sandimmune or Neoral)		☐ A lot	☐ Some	☐ No	
Etanercept (Enbrel)		☐ A lot	☐ Some	☐ No	
Infiximab (Remicade)		☐ A lot	☐ Some	☐ No	
Prosorba Column		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
OSTEOPOROSIS MEDICATIONS					
Estrogen (Premarin, etc.)		☐ A lot	☐ Some	☐ No	
Alendronate (Fosamax)		☐ A lot	☐ Some	☐ No	
Etidronate (Didronel)		☐ A lot	☐ Some	☐ No	
Raloxifene (Evista)		☐ A lot	☐ Some	☐ No	
Fluoride		☐ A lot	☐ Some	☐ No	
Calcitonim injection/nasal (Miacalin,Calcimar)		☐ A lot	☐ Some	☐ No	
Residronate (Actonel)		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
GOUT MEDICATIONS					
Probenecid (Benemid)		☐ A lot	☐ Some	☐ No	
Colchicine		☐ A lot	☐ Some	☐ No	
Allopurinal (Zyloprim/Loqurin)		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
Other:		☐ A lot	☐ Some	☐ No	
OTHERS					
Tamoxifen (Nolvadex)		☐ A lot	☐ Some	☐ No	
Tiludronate (Skelid)		☐ A lot	☐ Some	☐ No	
Cortisone / Prednisone		☐ A lot	☐ Some	☐ No	
Hyalgan / Synvisc Injections		☐ A lot	☐ Some	☐ No	
HERBAL OR NUTRITIONAL SUPPLEMENTS					
Supplements:		☐ A lot	☐ Some	☐ No	
Supplements:		☐ A lot	☐ Some	☐ No	
Supplements:		☐ A lot	☐ Some	☐ No	
Supplements:		☐ A lot	☐ Some	☐ No	

Have you participated in any clinical trials for new medications ☐ No ☐ Yes

If Yes, Please list: ____

Name: ____ Date: ______________ Age: __________ Sex: ☐ M ☐ F

Considering all the ways in which illness and health conditions may affect you
At this time, please make a mark below to show how you are doing:

Very Well I--I Very Poorly

How much pain have you had because of your condition over the past week?
Place a mark on the line below to indicate how severe your pain has been:

No Pain I--I Pain as Bad as It Could Be

Please answer the following questions, even if you feel that they may not be related to you at this time.

Answer exactly as you think or fee there are no “right” or “wrong” answers.

Check the one best answer for each question.

ACITIVITY LEVEL Right now, are you able to:		Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable to Do
1	Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
2.	Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
3.	Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
4.	Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
5.	Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
6.	Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
7.	Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
8.	Get in and out of a car, bus, train or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
9.	Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
10.	Participate in sports and games as you like?	☐ 0	☐ 1	☐ 2	☐ 3
	FN SUBTOTALS (FOR OFFICE USE ONLY)				
11.	Get a good night sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
12.	Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
13.	Deal with feeling of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
	PS Subtotals (FOR OFFICE USE ONLY)				

ADDITIONAL INFORMATION YOU WOULD LIKE TO DISCUSS DURING YOUR VISIT TODAY:

Name: ____ Date: ________________ Age: ___________ Sex: ☐ M ☐ F

For Official Use Only

GL

0-100

PN

0-100

FN EQUALS

1 = 0.33
2 = 0.87
3 = 1.0
4 = 1.33
5 = 1.67
6 = 2.0
7 = 2.33
8 = 2.67
9 = 3.0
10 = 3.33
11 = 3.67
12 = 4.0
13 = 4.33
14 = 4.67
15 = 5.0
16 = 5
17 = 5
18 = 6
19 = 6
20 = 6
21 = 7
22 = 7
23 = 7
24 = 8
25 = 8
26 = 8
27 = 9
28 = 9
29 = 9
30 = 1