



Scott Zashin M.D.
 We Understand. We're Here To Help!
 RHEUMATOLOGY

Patient History Form

Referred by (check one)

- Your Doctor Family Member Friend Patient of this office Internet Other _____

Name: _____ Birthdate: _____ / _____ / _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address _____ Age: _____ Sex: F M
CITY STATE ZIP Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: Never Married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses _____

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 _____

Name of person making referral: _____ Please let us know if you do not want a copy sent _____

The Name of physician providing your primary medical care: _____

Do you have an orthopedic surgeon? Yes No If yes, name: _____

Describe briefly your present symptoms. Include date symptoms began (approximate): _____

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

Please list the names of other practitioners 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 Name/Relationship	Yourself	Relative Name/Relationship
Arthritis (unknown type)		Lupus or "SLE"	
Osteoarthritis		Rheumatoid Arthritis	
Gout		Ankylosing Spondylitis	
Childhood Arthritis		Osteoporosis	
Other arthritis conditions:			

Patient's Name _____ Date _____ Physician's Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages? Yes No
 Cups/glasses per day? _____
 Do you smoke? Yes No Past - How long ago? _____
 How many packs per day? _____ How many years? _____
 Do-you drink alcohol? Yes No Number per week _____
 Has anyone ever told you to cut down on your drinking?
 Yes No
 Do you use drugs for reasons that are not medical? Yes No
 If yes, please list: _____

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
 Have you ever had a blood transfusion? Yes No If yes, date _____ Reaction _____
 Have you ever used intravenous drugs? Yes No If yes, date _____ Cocaine use? Yes No
 Any other risk factor for hepatitis (ex. tatoo or family member with hepatitis)
 Are you Heterosexual Homosexual Bisexual
 Are you receiving disability? Yes No Are you applying for disability? Yes No

Previous Operations

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

Any previous fractures? Yes No Describe: _____
 Any other serious injuries? Yes No Describe: _____

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 ages of each _____
 Health of children: _____

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

- Cancer (if yes, which relative & type of cancer) _____
- Colon Polyps
- Psoriasis
- Stroke
- Tuberculosis
- Heart attack
- High blood pressure

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")
 Cancer Heart problems Asthma
 Goiter Leukemia Stroke
 Cataracts Diabetes Epilepsy
 Depression Stomach ulcers Rheumatic fever
 Bad headaches Colitis Hepatitis or Jaundice
 Kidney disease Pneumonia Psoriasis
 Anemia HIV/AIDS High Blood Pressure
 Emphysema Glaucoma Tuberculosis
 Other significant illness (please list) _____

Natural or Alternative Therapies (chiropracty, magnets, massage, over-the-counter preparations, etc.)

Patient's Name _____ Date _____ Physician's Initials _____

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 ____/____/____
Date of last Colonoscopy ____/____/____ Date of last pelvic or prostate exam ____/____/____

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

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

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

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)</p>					
Pain Relievers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Proxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Minocycline		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Humira		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituxan		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orencia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Simponi		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued.

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actonel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Boniva		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reclast intravenous		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Febuxostat		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements					

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

If yes, list: _____
