

**– PRESENT MEDICATIONS –**

<b>Drug Allergies</b>		<b>Drug Sensitivities:</b>				
List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)						
NAME OF DRUG	DOSE (Include Strength and number of pills per day)	HOW LONG HAVE YOU TAKEN THIS MEDICATION?	PLEASE CHECK: HELPED?			
			A LOT	SOME	NOT AT ALL	NOT SURE
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

**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 medications, 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 (START DATE — END DATE)	BENEFICIARY RESULTS (CHECK)			REACTIONS (RASH, HEADACHE, ETC.)
		GOOD	FAIR	NONE	
1. Aspirin					
2. Arthrotec					
3. Celebrex					
4. Clinoril (Sulindac)					
5. Daypro (Oxaprozin)					
6. Feldene (Piroxicam)					
7. Ibuprofen (Motrin/Advil)					
8. Indocin (Indomethacin)					
9. Lodine (Etodolac)					
10. Mobic (Meloxicam)					
11. Naprosyn (Naproxen)					
12. Neurontin (Gabapentin)					
13. Orudis (Oruvail)					
14. Relafen (Nabumetone)					
15. Salsalate					
16. Tramadol (Ultram/Utracet)					
17. Tylenol					
18. Voltaren (Diclofenac Sodium)					
19. Allopurinol					
20. Arava (Leflunomide)					
21. Azulfidine					
22. Colchicine					
23. Cortisone (Prednisone)					
24. Cytoxan (Cyclophosphamide)					
25. Enbrel					
26. Gold					
27. Humira					
28. Imuran (Azathioprine)					
29. Kineret					
30. Methotrexate					
31. Neoral					
32. Penicillamine					
33. Plaquenil (Hydroxychloroquine)					
34. Remicade					
35. Avinza					
36. Darvon (Darvocet N100)					
37. Oxycontin					
38. Percocet (Oxycodone)					
39. Vicodin (Hydrocodone)					



# Arizona Arthritis & Rheumatology Associates, P.C.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Birth Date \_\_\_\_\_

## PRESENT MEDICAL INFORMATION

DESCRIBE BRIEFLY YOUR PRESENT SYMPTOMS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE SYMPTOMS BEGAN APPROX.: \_\_\_\_\_ DIAGNOSIS GIVEN? (PLEASE LIST) \_\_\_\_\_

PREVIOUS TREATMENT FOR THIS PROBLEM (INCLUDE PHYSICAL THERAPY, SURGERY AND INJECTIONS; MEDICATIONS TO BE LISTED LATER)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST THE NAMES OF OTHER PRACTITIONERS YOU HAVE SEEN FOR THIS OR RELATED PROBLEMS:

NAME	SPECIALTY	PHONE::

PRIMARY CARE PHYSICIAN

## RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
_____ Crohns	_____	_____ Iritis	_____
_____ Arthritis (type unknown)	_____	_____ Psoriasis	_____
_____ Osteoarthritis	_____	_____ Lupus or "SLE"	_____
_____ Rheumatoid arthritis	_____	_____ Ankylosing spondylitis	_____
_____ Gout	_____	_____ Childhood arthritis	_____
_____ Fibromyalgia	_____	_____ Osteoporosis	_____
		_____ Colitis	_____

Other arthritis conditions: \_\_\_\_\_

## FAMILY HEALTH HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
<b>Father</b>				
<b>Mother</b>				

Number of Brothers \_\_\_\_\_ Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_

Number of Sisters \_\_\_\_\_ Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_

Number of Pregnancies \_\_\_\_\_ Number of Living Children \_\_\_\_\_ Number of Deceased Children \_\_\_\_\_ List ages of each \_\_\_\_\_

Number of Miscarriages \_\_\_\_\_ Are you trying to get pregnant? \_\_\_\_\_

Serious Illnesses of children \_\_\_\_\_

\_\_\_\_\_

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

- Cancer \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Asthma \_\_\_\_\_
- Leukemia \_\_\_\_\_  Bleeding Tendency \_\_\_\_\_  Tuberculosis \_\_\_\_\_
- Stroke \_\_\_\_\_  Alcoholism \_\_\_\_\_  Diabetes \_\_\_\_\_
- Colitis \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  Goiter/ \_\_\_\_\_
- Heart Disease \_\_\_\_\_  Epilepsy \_\_\_\_\_  Thyroid Disease \_\_\_\_\_

**PAST PERSONAL MEDICAL HISTORY**

Have you had any of the following? If yes, please check and indicate date of onset:  High Cholesterol \_\_\_\_\_  
 Cancer \_\_\_\_\_  Heart Problems \_\_\_\_\_  Asthma \_\_\_\_\_  Goiter/Thyroid Disease \_\_\_\_\_  
 Leukemia \_\_\_\_\_  Stroke \_\_\_\_\_  Cataracts \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Seizure \_\_\_\_\_  Depression \_\_\_\_\_  Stomach Ulcers \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  
 Bad Headaches \_\_\_\_\_  Hepatitis \_\_\_\_\_  Colitis \_\_\_\_\_  Kidney Disease \_\_\_\_\_  
 Pneumonia \_\_\_\_\_  Psoriasis \_\_\_\_\_  Anemia \_\_\_\_\_  Hypertension \_\_\_\_\_  
 Valley Fever \_\_\_\_\_  Mental Disorder \_\_\_\_\_  Bleeding Disorders \_\_\_\_\_  Irritable Bowel Syndrome \_\_\_\_\_  
Other Significant illness (please list) \_\_\_\_\_

**PREVIOUS OPERATIONS**

Type	Year	Surgeon
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____

Any previous fractures?  No  Yes If yes, describe \_\_\_\_\_  
Any prior transfusion?  No  Yes Dates \_\_\_\_\_  
Any other serious injuries?  No  Yes If yes, describe \_\_\_\_\_  
Childhood illnesses  Unremarkable \_\_\_\_\_

**DIET**

**EXERCISE**

Do you adhere to a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> Low Salt <input type="checkbox"/> Low Fat <input type="checkbox"/> Low Cholesterol <input type="checkbox"/> Other <input type="checkbox"/> Low Carb/High Protein	Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list exercise typical in a week Type of exercise _____ Duration _____ Frequency/week _____ _____ _____
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**SOCIAL HISTORY**

Do you smoke cigarettes?  Never  Yes, # packs/day \_\_\_\_\_  Yes but quit how many years ago \_\_\_\_\_  
Do you drink alcohol?  No  Yes \_\_\_\_\_ #drinks/week (circle): Beer, Wine or Spirits  
Marital status  Never married  Married  Divorced  Separated  Widowed  
Spouse  Alive/age \_\_\_\_\_  Deceased/age \_\_\_\_\_ Major Illness of spouse \_\_\_\_\_  
Where were you born and raised? \_\_\_\_\_ How long in AZ? \_\_\_\_\_

**HOME CONDITIONS**

Check one:  House  Apartment  
Do you have stairs to climb?  Yes  No If yes, how many? \_\_\_\_\_  
Number of people in household \_\_\_\_\_ Relationship, and age of each? \_\_\_\_\_  
Who does most of the housework? \_\_\_\_\_ Who does most of the shopping? \_\_\_\_\_

**EDUCATION (circle highest level attended)**

Grade School    Junior High School    High School 10 11 12    Trade School    College 1 2 3 4    Graduate School

**EMPLOYMENT**

Occupation: \_\_\_\_\_ Number of hours worked/average per week \_\_\_\_\_  
Employer: \_\_\_\_\_  
Retired?  No  Yes Disabled?  No  Yes If yes, when, why: \_\_\_\_\_

## SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

**GENERAL:**

- Recent weight gain/amount \_\_\_\_\_
- Recent loss of weight/amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

**NERVOUS SYSTEM:**

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Numbness or tingling
- Memory loss

**EARS:**

- Ringing in ears
- Loss of hearing

**EYES:**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feeling of something in your eyes

**NOSE:**

- Nosebleeds
- Loss of smell
- Dryness

**MOUTH:**

- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness

**THROAT:**

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

**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
- High blood pressure
- Heart murmurs
- Cough
- Coughing of blood
- Wheezing
- Night sweats

**STOMACH AND INTESTINES:**

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

**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
- Protein in urine
- Prostate trouble

**BLOOD:**

- Anemia
- Bleeding tendency
- Low white count /  Low platelets

**SKIN:**

- Easy bruising
- Redness
- Rash
- Sores or ulcers on fingers
- Hives
- Sun sensitive rash (sun allergy)
- Tightness
- Nodules/bumps
- Excessive hair loss
- Frequent color changes of hands or feet in the cold

**MUSCLES/JOINTS/BONES:**

- Morning stiffness
  - Lasting how long:
  - Minutes
  - Hours
  - Joint Pain
  - Numbness or tingling
  - Muscle weakness
  - Muscle tenderness
  - Joint swelling
- List joints affected in the last 6 months:

Date of last eye exam \_\_\_\_\_ Date of last chest x-ray \_\_\_\_\_ Date of last Tuberculosis test \_\_\_\_\_

Height at greatest \_\_\_\_\_ Last Bone Density Exam \_\_\_\_\_

**MENSTRUAL:**

Age when periods began: \_\_\_\_\_ Periods regular?  Yes  No How many days apart \_\_\_\_\_ Date of last period \_\_\_\_\_  
 Date of last Pap smear \_\_\_\_\_ Bleeding after menopause \_\_\_\_\_

## PRESENT HEALTH QUESTIONNAIRE

On the scale below, circle a number which best describes your situation. Most of the time, I function...

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

How many pillows do you use to sleep on each night? \_\_\_\_\_

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

Because of health problems, do you have difficulty: *(Please check the appropriate response for each question)*

	Usually	Sometimes	No
Using your hands to grasp small objects: (buttons, toothbrush, pencil, etc.) .....	_____	_____	_____
Walking? .....	_____	_____	_____
Climbing stairs? .....	_____	_____	_____
Descending stairs? .....	_____	_____	_____
Sitting down? .....	_____	_____	_____
Getting up from a chair? .....	_____	_____	_____
Touching your feet while seated? .....	_____	_____	_____
Reaching behind your back? .....	_____	_____	_____
Reaching behind your head? .....	_____	_____	_____
Dressing yourself? .....	_____	_____	_____
Going to sleep? .....	_____	_____	_____
Staying asleep due to pain? .....	_____	_____	_____
Obtaining restful sleep? .....	_____	_____	_____
Bathing? .....	_____	_____	_____
Eating? .....	_____	_____	_____
Working? .....	_____	_____	_____
Getting along with other family members? .....	_____	_____	_____
Engaging in leisure time activities? .....	_____	_____	_____
With morning stiffness? .....	_____	_____	_____
Do you use a cane, crutches, a walker or wheelchair? <i>(circle item)</i> .....	_____	_____	_____
What is the hardest thing for you to do? _____			
Are you receiving disability? .....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you applying for disability? .....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a medically related lawsuit pending? .....		<input type="checkbox"/> Yes	<input type="checkbox"/> No