Arizona Arthritis & Rheumatology Associates, P.C.

General Phone (480) 443-8400
Fax (480) 443-8697

Medical History

PATIENT INFORMATION

TODAY'S DATE	PATIENT NAME		BIRTH DATE
RACE	ETHNICITY		
PATIENT OCCUPATION			

List of Consultants and Primary Care Doctor Information (Circle the referring doctor)

PRIMARY CARE DOCTOR NAME	PHONE	FAX
CONSULTANT NAME & SPECIALTY	PHONE	FAX
CONSULTANT NAME & SPECIALTY	PHONE	FAX

Chief Reason for Referral to Rheumatology (Main symptom, duration, location, treatments)

Past Medical History (Check formal diagnoses for which you may or may not take medications with approximate year of onset)

☐ High Cholesterol year	☐ Stroke year	☐ GERD/Acid Reflux year	☐ Depression year
☐ Hypertension/High BP year	☐ Arrhythmia (irregular heart beat) year	☐ Stomach ulcer year	☐ Anxiety Disorder year
☐ Type I Diabetes (Insulin) year	☐ Specific bleeding disorder year	☐ Fatty liver year	☐ Insomnia year
☐ Type II Diabetes year	☐ Pulmonary Hypertension year	☐ Hepatitis B year	☐ Obstructive Sleep Apnea year
☐ Thyroid Disease Type: year	☐ Interstitial Lung Disease year	☐ Hepatitis C year	☐ Alcoholism year ☐ Drug Addiction
☐ Chronic Kidney Disease year	☐ Pleural Effusion year	☐ Celiac Sprue year	☐ Coccidiomycosis (confirmed Valley Fever) year
☐ Renal or Kidney Stones year	☐ Pericardial Effusion year	☐ Irritable Bowel Syndrome year	☐ HIV ☐ TB year ☐ STD ☐ Lyme Disease
☐ Asthma year	☐ COPD or Emphysema year	☐ Seizure Disorder year	☐ Major Trauma year
☐ Blood Clots ☐ DVT year ☐ PE	☐ Coronary Artery Disease year	☐ Congestive Heart Failure year	☐ XRT/Radiation Therapy year
☐ Multiple Sclerosis year	☐ Cancer Type: year	☐ Migraine year	☐ Others year

Past Medical History - Rheumatology Specific (Check formal diagnoses and give year of onset)

☐ Osteoarthritis Location: year	☐ Fracture spine, hip, other Site: year	☐ Discoid Lupus year	☐ Ulcerative Colitis year ☐ Crohn's Disease
☐ Degenerative discs in cervical spine year	☐ Fibromyalgia year	☐ Systemic Vasculitis Type: year	☐ Ankylosing Spondylitis year
☐ Degenerative discs in lumbar spine year	☐ Gout year	☐ Polymyalgia Rheumatica year	☐ Iritis ☐ Uveitis year ☐ Scleritis
☐ Osteopenia year	☐ Rheumatoid Arthritis year	☐ Psoriasis year	☐ Psoriatic Arthritis year
☐ Osteoporosis year	☐ Systemic Lupus Erythematosus (SLE) year	☐ Autoimmune liver year ☐ Autoimmune thyroid disease	☐ Others year

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Are you currently on birth control?	YES ☐ NO ☐
Are your currently pregnant or trying to concieve?	YES ☐ NO ☐

Past Surgical History (List past major surgeries, year of surgery, left/right side if applicable)

1.	2.	3.
4.	5.	6.

Allergies to drug, latex or other (List Allergies and Reactions)

1.	2.	3.	4.
5.	6.	7.	8.

Previous Medications (List any past prescription or over the counter medications used that you do not currently take)

	Name	Year Started and Stopped	Major Side Effects (if any)	Benefit YES NO MAYBE
1.				☐ ☐ ☐
2.				☐ ☐ ☐
3.				☐ ☐ ☐
4.				☐ ☐ ☐
5.				☐ ☐ ☐
6.				☐ ☐ ☐

Current Medications (List prescription or over the counter medications you actively take)

	Name	Tablet Strength (Mgs, grams etc.)	Frequency (once/day, twice/day, weekly, etc.)	Year started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

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Family History (Check if family member has a CONFIRMED diagnosis and give relationship)

☐ Osteoarthritis who?	☐ Psoriasis who?	☐ Polymyalgia who?	☐ Blood clots who?
☐ Osteoporosis who?	☐ Crohn's Disease who?	☐ Systemic Vasculitis who?	☐ Hypertension who?
☐ Gout who?	☐ Ulcerative Colitis who?	☐ Parent with hip/spine fracture who?	☐ Diabetes who?
☐ Rheumatoid Arthritis who?	☐ Ankylosing Spondylitis who?	☐ Cancer who?	☐ Heart Disease who?
☐ Systemic Lupus who?	☐ Iritis or Scleritis who?	☐ Tuberculosis who?	☐ Stroke who?

Social History (Check or Circle if Applicable)

1.	**Cigarette Smoking**	Never ☐	Current ☐	# per day: Total years smoked:	Former ☐	Quit date: Total years smoked:
2.	**Alcohol Use**	☐ Yes ☐ No	# Drinks/week:	☐ Beer	☐ Wine	☐ Spirit
3.	**Drug Abuse** (marijuana, illicit drugs, prescription narcotics)	☐ Yes ☐ No	Type of Drug:			
4.	**Currently Breastfeeding**	☐ Yes ☐ No				
5.	Last Menstrual Period:	Age at Menopause:	Last DEXA scan:			
6.	Last Eye Exam:	Last Colonoscopy:	Last Mammogram:	Last PAP smear:		
7.	**Are you on Disability or Applying for it?**	☐ Yes ☐ No	Reason:			

System Review (SELECT RECENT OR ACTIVE symptoms associated with the REASON FOR REFERRAL)

GENERAL	NECK	GASTROINTESTINAL	MUSCULOSKELETAL
☐ Weight loss Amount/time:	☐ Hoarseness (excessive)	☐ Nausea	☐ Joint pain location
☐ Weight gain Amount/time:	☐ Enlarged Node or large thyroid	☐ Abdominal pain	☐ Joint swelling
☐ Fatigue	**RESPIRATORY**	☐ Vomitting	☐ Morning stiffness duration
☐ Fever	☐ Cough (dry or productive)	☐ Vomitting blood	☐ Muscle pain location
SKIN	☐ Shortness of breath at rest	☐ Blood in stools	☐ Low back pain
☐ Rash	☐ Shortness of breath at exertion	☐ Black stools	☐ Neck pain
☐ Raynaud's (color changes in hands/feet when cold)	☐ Coughing of blood (hemoptysis)	☐ Hemorrhoids	**NEUROLOGIC AND PSYCHIATRIC**
☐ Hair loss (patchy or thinning)	☐ Wheezing	☐ Heartburn (current)	☐ Active Insomnia
SPECIAL SENSES	☐ Snoring	☐ Difficulty swallowing	☐ Localized loss of muscle power
☐ Hearing Loss	☐ Sputum production (colored)	☐ Diarrhea	☐ Numbness location
☐ Dry Eyes	**BREAST**	**GENITOURINARY**	☐ Tingling location
☐ Eye pain with eye redness	☐ Mass or lump or discharge	☐ Blood in urine	☐ Difficulty with speech
☐ Double Vision	**CARDIOVASCULAR**	☐ Painful urination	☐ Active Anxiety
☐ Vision Loss (blindness)	☐ Chest pain (new and active)	☐ Flank pain	☐ Active Depression
☐ Dry mouth (excessive)	☐ Leg swelling (new or excessive)	☐ Genital ulcer	**ENDOCRINE**
☐ Oral Sores (recurrent)	☐ History of Heart Murmur	☐ Prostate trouble	☐ Anorexia
☐ Chronic Sinusitis	**HEMATOLOGIC**	☐ Foamy urine	☐ Cold intolerance (excessive)
☐ Nosebleeds (frequent)	☐ Abdominal bleeding or bruising		

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HEALTH QUESTIONAIRE: Please select and circle a number for each activity after reading about the task.
0 — no difficulty, 1 — some difficulty, 2 — much difficulty, 3 — unable to do
If you do not wish to fill this information, please indicate "Do not wish to fill".

Dress yourself	Take a bath	Lift a full cup or glass to your mouth	Run errands and shop
Shampoo hair	Get on and off toilet	Open a new milk carton	Get in and out of car
Stand up from chair	Reach and get down a 5lb object from above your head	Walk outdoors on flat ground	Do chores (vacuum, yard work)
Get in and out of bed	Bend down to pick up	Open previously opened jar	Climb up 5 stairs
Cut your meat	Open car doors	Turn faucets on and off	Wash and dry your body

DO YOU USE ANY OF THE FOLLOWING?

☐ Cane	☐ Walker	☐ Crutches	☐ Wheelchair
☐ Built up chair	☐ Built up utensils	☐ Devices to dress	☐ Raised toilet seat
☐ Bathtub bar or seat	☐ Long-handled appliances for reach		

VISUAL ANALOG PAIN SCALE

Please report current pain intensity by drawing a perpendicular line on the horizontal line below.

Worst imaginable pain 10 ——————————————————— **0 No pain**