Health History – The Seattle Arthritis Clinic

Name: Last	First		MI	Date:
Birthdate:	Location:		_ E-Mail :	
REASON FOR VISIT Referring Provider:		Preferred Pr	Gender: _	
Primary Care Provid		Preferred Ph	_	
<u>Allergies:</u> □ No Allergies _ _ _	Medication or Substance		<u>R</u>	eaction
Current Medications: OR See Attached List	Label - Name			<u>Frequency</u>

Rheumatologic (Arthritis) History

Describe your present symptoms:

Please shade all the locations of your pain over the past week on the body figures and hands. Example: Date symptoms began (approximate): LEFT Diagnosis: LEFT RIGHT Previous treatment(s) for this problem. (Please include physical therapy, surgery, and injections. Medications should be listed on the medications and supplements section on the first page.) Please list the names of other practitioners you have RIGH seen for this problem: Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment - Listening to the patient - A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

UW Medicine

Harborview Medical Center – University of Washington Medical Center UW Neighborhood Clinics – Valley Medical Center University of Washington Physicians Seattle, Washington

HEALTH HISTORY ARTHRITIS





UH3839 REV JAN 20

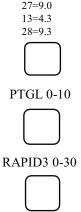
PLACE PATIENT LABEL HERE

Please check (\checkmark) the ONE best answer for your abil	i ties at tl	his time:				
At this moment, are you able to:	Without Any Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do	,	FN 0-10
a. Dress yourself, including tying shoelaces and	0	1	2	3		\Box
doing buttons?						1=0.3 16=5.3
b. Get in and out of bed?	0	1	2	3		2=0.7 17=5.7
c. Lift a full cup or glass to your mouth?	0	1	2	3		3=1.0 18=6.0 4=1.3 19=6.3
d. Walk outdoors on flat ground?	0	1	2	3		5=1.7 20=6.7
e. Wash and dry your entire body?	0	1	2	3		6=2.0 21=7.0
f. Bend down to pick up clothing from the floor?	0	1	2	3		7=2.3 22=7.3 8=2.7 23=7.7
g. Turn regular faucets on and off?	0	1	2	3		9=3.0 24=8.0
h. Get in and out of the car, bus, train or airplane?	0	1	2	3		10=3.3
i. Walk two miles?	0	1	2	3		25=8.3
j. Participate in sports and games as you would	0	1	2	3		11=3.7 26=8.7
like?						12=4.0
k. Get a good night's sleep?	0	1	2	3		27=9.0
I. Deal with feelings of anxiety or nervousness?	0	1	2	3		13=4.3 28=9.3
m. Deal with feelings of depression or "blue"?	0	1	2	3		20-9.5

1 / 1 1 1 - :

1. How much pain have you been in because of your condition over the past week? Please indicate below how severe your pain has been:

NO	\bigcirc	ļ
PAIN	0 0.5 1 1.5 2 2.0 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 AS IT COULD BE	ļ

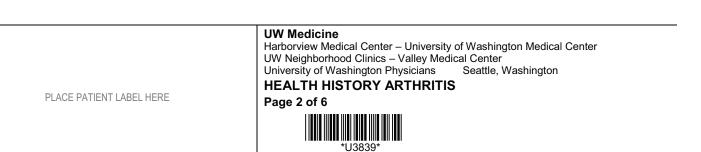


2. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

WELL 0 0.5 1 1.5 2 2.0 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 POORLY

Screening

Have you fallen in the past year? \Box Yes \Box No Are you afraid of falling? \Box Yes \Box No Do you have issues with balance or feeling unsteady? \Box Yes \Box No Do you feel safe at home? □ Yes □ No



eview of Systems (Curre	nt Symptoms) – Please	heck only if these are bothering you at this time
Constitutional: □ Fevers □ Weight Gain	☐ Fatigue☐ Weight Loss	Head/Eyes: □ Cataracts □ Dry Eyes □ Poor Vision □ Color Blindness □ Eye Redness
Ears/ Nose/ Mouth/ Thros Hearing Loss Heavy Snoring Oral Ulcers Dry Mouth	<u>at:</u> □ Chronic Sinus Conge □ Bad Teeth □ Nose Bleeds	tion Cough Shortness of Breath Shortness of Breath While Lying Flat With Exertion
Heart: ☐ Chest Pain ☐ Irregular Heartbeat ☐ Color Changes of Hands & Feet in Cold	 □ Palpitations □ High Blood Pressure 	Genitourinary: □ Burning with Urination □ Sexual Problems □ Burning with Urination □ Blood in Urine □ Leakage of Urine □ Genital Ulcers □ Penile Discharge □ Vaginal Discharge □
Gastrointestinal:Poor AppetiteStomach PainDiarrheaOther (Please list):	NauseaConstipationAbdominal Swelling	 Vomiting Vomiting Blood Black Tarry Stools Trouble Swallowing Rectal Bleeding
Muscle/ Bones: Chronic Pain Muscle Weakness Muscle Wasting Joint Swelling List joints affected in the last 6 months):	 Muscle Cramping Arthritis Morning Stiffness Lasting how long? min 	Neurological: Seizures (Epilepsy) Headaches Tremor (Shaking) Numbness Tingling Loss of sensation Tremor (Shaking)
Vascular: □ Blood Clots	Varicose Veins	Skin: Image: Rash Image: Jaundice Image: Itching Image: Psoriasis
Psychosocial:	Feeling Worthless	Sexual Problems
Endocrine: Hot Flashes Excessive Thirst	□ Intolerance to Heat □ Intolerance to Cold	Blood/ Lymph: Swollen Lymph Nodes Easy Bruising Easy Bleeding
ecialty Medical History Ankylosing Spondylitis Antiphospholipid Syndrome Behcet's Disease Bursitis De Quervain's Tendinosis Dermatomyositis Fibromyalgia Gout Inflammatory Bowel Diseas	 Interstitial Lung Disea Kidney Disease Low Back Pain Lupus Myopathy Osteoarthritis Osteoporosis Plantar Fasciitis 	heck box for those conditions you have now or have ever have ae Polymyalgia Rheumatica Shoulder Problem Polymyositis Sjogren's Syndrome Pseudogout Spinal Stenosis Psoriasis Spondyloarthropathy Psoriatic Arthritis Tendonitis Rheumatoid Arthritis Trigger Finger Sarcoidosis Uveitis Scleroderma Vasculitis
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Rheumatology Medications

	Methotrexate	Leflunomide	Humira	Enbrel	Actemra	Benlysta	Cimzia	Orencia	Remicade	Rituxan	Simponi	Simponi Aria	Cosentyx	Stelara	Hydroxychloroquine	Otezla	Plaquenil	Sulfasalazine	Minocycline	Kineret	Anti-Inflammatories	Cytoxan	Prednisone			Comments
Currently Taking																										
Previously Taken																										
Helpful																										
Not Helpful																										
Tolerated																										
Not Tolerated																										

General Medical History	Please check box for those conditions you have now or have ever h	ad.
 No Past Medical History Allergic Rhinitis Anemia Anesthesia Problems Anxiety Arthritis Asthma Bleeding/ Clotting Disorder Blood Transfusion Cancer Emphysema Jaundice Colitis Other (Please list and inclust) 	ICongestive Heart FailureHeadachesMusculoskeletalICOPDHeart MurmurMyocardial InfarctionICoronary AtherosclerosisHepatitisOsteoporosisIDepressionHIV/AIDSPPDIDiabetes Type 1HypertensionSeizuresIDiabetes Type 2InsomniaStrokeIGastric UlcerKidney DiseaseSubstance AbuseIGERDLipid / CholesterolThyroid DiseaseIGoiterCataractsNervous BreakdownIHeart ProblemsLeukemiaStomach UlcersIPneumoniaEpilepsyRheumatic FeverIHigh Blood PressureTuberculosisInservent	
Surgical History	Please check box for any surgery you have had. Indicate the year (YY	YY).
 No Past Surgical History Achilles Repair () Appendectomy () Back Surgery () Breast Surgery () CABG () Other (Please list): 	Carpal Tunnel Release () Hip Surgery () Nephrectomy () Elbow Surgery () Joint Replacement – Hip Oophorectomy () Fracture Surgery () Joint Replacement – Knee Splenectomy () Gall Bladder Surgery () Joint Replacement – Knee Splenectomy () Hand Surgery () Joint Replacement – Shoulder () Wrist Surgery () Neck Surgery () Neck Surgery () Neck Surgery ())
Any previous fractures? Any other serious injuries?	Yes No Describe:	
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Family History					
		Circle	Current age/ Age at death		Current heath/ Cause of death
Father	Alive	Deceased			
Mother	Alive	Deceased			
Sister	Alive	Deceased			
Brother Maternal	Alive	Deceased			
Grandmother Maternal	Alive	Deceased			
Grandfather Paternal	Alive	Deceased			
Grandmother Paternal	Alive	Deceased			
Grandfather	Alive	Deceased			
Number of siblir	ngs		Number living		Number deceased
Number of child	ren		Number living		Number deceased
List ages of chil	dren			Health of Children	
	-			-	

**Type of Cancer or Disease:

Family Rheumatologic (Arthritis) History

At any time has a blood relative had any of the following? (Check if "yes")

Relative Name/Relationship		Relative Name/Relationship	
	Arthritis (unknown type)		Lupus or "SLE"
	Osteoarthritis		Rheumatoid Arthritis
	Gout		Ankylosing Spondylitis
	Childhood arthritis		Osteoporosis
	Psoriasis		Inflammatory bowel disease

Alternative Medical History

Please list any Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

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Social History

□ Never Married □ Married □ I	Domestic Pa	artner (S	pouse/Partner Nam	ne:) # Kids
\Box Divorced \Box Separated \Box Wide	owed Spo	use/Sign	ificant Other (Circle	e One): Alive	/ Deceased	Age/Deceased
	Spo	use/Sign	ificant Other Major	Illness		
Education (Highest Level of Educ	cation Comp	leted):				
Grade School: 7 8 9 10 11 12	College	: 1 2 3	4 Graduate S	School		
Are you working? □ Yes What	it do you do	?	#⊦	lours Worke	d/Average per	week
🗆 No 🗆 Re	etired 🗆 Dis	abled				
Do you drink caffeinated beverage	jes? 🗆 Ye	es 🗆 N	o Drinks per Day			
Do you use tobacco products?	Never	🗆 Yes	Packs per Day _	Year	s Smoked	Date Quit
	Type(s) of	Tobacco	: 🗆 Cigarettes 🛛	Cigars 🗆 I	E-Cigarettes	Chew Snuff
Do you drink alcohol?	□ Yes □	No	Drinks per Day		Drinks per We	eek
Do you use recreational drugs?	□ Never	🗆 Yes –	- Use per Week			
	Have you	ever used	d intravenous (IV) d	lrugs: 🗆 Ye	s 🗆 No	
Do you exercise regularly?	🗆 Yes 🗆	No Ту	/pe	Amoun	it per week	· · · · · · · · · · · · · · · · · · ·
Do you get enough sleep at night	t? 🗆 Yes	🗆 No				
Do you wake up feeling rested?	🗆 Yes	🗆 No				
Are you sexually active?	\Box Yes	🗆 No	Partners: Male	□ Female	Birth Control	
Health Maintenance						
	Yes No					

General	Colonoscopy		When:	Where:
	Dexa/Bone Density		When:	Where:
	Eye Exam		When:	Where:
	Dental Exam		When:	Where:
	Tuberculosis Test		When:	Where:
	Last Mammogram		When:	Where:
	Last Pap		When:	Where:
	Last Prostate Exam		When:	Where:
Vaccines	Influenza		When:	Where:
	Pneumococcal		When:	Where:
	Shingles		When:	Where:
	Hepatitis B (or titer)		When:	Where:

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