Health History – The Seattle Arthritis Clinic

Name: Last ________________________ **First** ________________________ **MI** ________ **Date:** __________

Birthdate: ___________________________ **Location:** ____________________ **E-Mail :**_______________________

REASON FOR VISIT: ______________________________ **Gender:** ______________________

Referring Provider: ______________________________ **Preferred Pronoun:** ______________________

Primary Care Provider ______________________________ **Preferred Pharmacy:** ______________________

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications: OR ☐ See Attached List	**Label - Name**	**Dose**	**Frequency**

Rheumatologic (Arthritis) History

Describe your present symptoms:

____

____

____

____

Date symptoms began (approximate): ______________

Diagnosis: ______________________________

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 seen for this problem:

____

____

____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

LEFT RIGHT LEFT

LEFT RIGHT

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.

PLACE PATIENT LABEL HERE

Rheumatologic (Arthritis) History (cont.)

Please check (✓) the **ONE** best answer for **your abilities** at this time:				
At this moment, are you able to:	Without Any Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
b. Get in and out of bed?	____0	____1	____2	____3
c. Lift a full cup or glass to your mouth?	____0	____1	____2	____3
d. Walk outdoors on flat ground?	____0	____1	____2	____3
e. Wash and dry your entire body?	____0	____1	____2	____3
f. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
g. Turn regular faucets on and off?	____0	____1	____2	____3
h. Get in and out of the car, bus, train or airplane?	____0	____1	____2	____3
i. Walk two miles?	____0	____1	____2	____3
j. Participate in sports and games as you would like?	____0	____1	____2	____3
k. Get a good night's sleep?	____0	____1	____2	____3
l. Deal with feelings of anxiety or nervousness?	____0	____1	____2	____3
m. Deal with feelings of depression or "blue"?	____0	____1	____2	____3

FN 0-10

☐

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3
25=8.3
11=3.7
26=8.7
12=4.0
27=9.0
13=4.3
28=9.3

☐

PTGL 0-10

☐

RAPID3 0-30

☐

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 PAIN ○ **PAIN AS BAD AS IT COULD BE**

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

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

VERY WELL ○ **VERY POORLY**

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

Screening

Have you fallen in the past year? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Review of Systems (Current Symptoms) – Please check only if these are bothering you at this time

Constitutional:
- ☐ Fevers
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Weight Loss

Head/Eyes:
- ☐ Cataracts
- ☐ Poor Vision
- ☐ Eye Redness
- ☐ Dry Eyes
- ☐ Color Blindness

Ears/ Nose/ Mouth/ Throat:
- ☐ Hearing Loss
- ☐ Heavy Snoring
- ☐ Oral Ulcers
- ☐ Dry Mouth
- ☐ Chronic Sinus Congestion
- ☐ Bad Teeth
- ☐ Nose Bleeds

Respiratory (Lungs):
- ☐ Cough
- ☐ Shortness of Breath With Exertion
- ☐ Shortness of Breath While Lying Flat

Heart:
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Color Changes of Hands & Feet in Cold
- ☐ Palpitations
- ☐ High Blood Pressure

Genitourinary:
- ☐ Sexual Problems
- ☐ Blood in Urine
- ☐ Genital Ulcers
- ☐ Vaginal Discharge
- ☐ Burning with Urination
- ☐ Leakage of Urine
- ☐ Penile Discharge

Gastrointestinal:
- ☐ Poor Appetite
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Nausea
- ☐ Constipation
- ☐ Abdominal Swelling
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Trouble Swallowing
- ☐ Heartburn/Indigestion
- ☐ Black Tarry Stools
- ☐ Rectal Bleeding
- ☐ Other (Please list): ____________________

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_______hrs

Neurological:
- ☐ Headaches
- ☐ Confusion
- ☐ Numbness
- ☐ Loss of sensation
- ☐ Seizures (Epilepsy)
- ☐ Tremor (Shaking)
- ☐ Tingling

Vascular:
- ☐ Blood Clots
- ☐ Varicose Veins

Skin:
- ☐ Rash
- ☐ Itching
- ☐ Jaundice
- ☐ Psoriasis

Psychosocial:
- ☐ Anxiety / Nerves
- ☐ Feeling Worthless
- ☐ Sexual Problems
- ☐ Sleep Problems
- ☐ Depression

Endocrine:
- ☐ Hot Flashes
- ☐ Excessive Thirst
- ☐ Intolerance to Heat
- ☐ Intolerance to Cold

Blood/ Lymph:
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Easy Bleeding

Specialty Medical History — Please check box for those conditions you have now or have ever had.

- ☐ Ankylosing Spondylitis
- ☐ Antiphospholipid Syndrome
- ☐ Behcet's Disease
- ☐ Bursitis
- ☐ De Quervain's Tendinosis
- ☐ Dermatomyositis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Inflammatory Bowel Disease
- ☐ Interstitial Lung Disease
- ☐ Kidney Disease
- ☐ Low Back Pain
- ☐ Lupus
- ☐ Myopathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Plantar Fasciitis
- ☐ Polymyalgia Rheumatica
- ☐ Polymyositis
- ☐ Pseudogout
- ☐ Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Scleroderma
- ☐ Shoulder Problem
- ☐ Sjogren's Syndrome
- ☐ Spinal Stenosis
- ☐ Spondyloarthropathy
- ☐ Tendonitis
- ☐ Trigger Finger
- ☐ Uveitis
- ☐ Vasculitis

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 had.

- ☐ No Past Medical History
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/ Clotting Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Emphysema
- ☐ Jaundice
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Heart Problems
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lipid / Cholesterol
- ☐ Lung Disease
- ☐ Cataracts
- ☐ Leukemia
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Musculoskeletal
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ PPD
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Nervous Breakdown
- ☐ Stomach Ulcers
- ☐ Rheumatic Fever
- ☐
- ☐ Other (Please list and include any significant illness): ____________________

Surgical History

Please check box for any surgery you have had. Indicate the year (YYYY).

- ☐ No Past Surgical History
- ☐ Achilles Repair (____)
- ☐ Appendectomy (____)
- ☐ Back Surgery (____)
- ☐ Breast Surgery (____)
- ☐ CABG (____)
- ☐ Carpal Tunnel Release (___)
- ☐ Elbow Surgery (____)
- ☐ Foot Surgery (____)
- ☐ Fracture Surgery (____)
- ☐ Gall Bladder Surgery (____)
- ☐ Hand Surgery (____)
- ☐ Hip Surgery (____)
- ☐ Joint Replacement – Hip (____)
- ☐ Joint Replacement – Knee (____)
- ☐ Joint Replacement – Shoulder (____)
- ☐ Knee Surgery (____)
- ☐ Neck Surgery (____)
- ☐ Nephrectomy (____)
- ☐ Oophorectomy (____)
- ☐ Shoulder Surgery (____)
- ☐ Splenectomy (____)
- ☐ Wrist Surgery (____)
- ☐ Other (Please list): ____________________

____

	Yes	No	
Any previous fractures?	☐	☐	Describe: ____________________
Any other serious injuries?	☐	☐	Describe: ____________________

PLACE PATIENT LABEL HERE

Family History

	Circle		Current age/ Age at death	Current heath/ Cause of death
Father	Alive	Deceased		
Mother	Alive	Deceased		
Sister	Alive	Deceased		
Brother	Alive	Deceased		
Maternal Grandmother	Alive	Deceased		
Maternal Grandfather	Alive	Deceased		
Paternal Grandmother	Alive	Deceased		
Paternal Grandfather	Alive	Deceased		

Number of siblings ______ Number living ______ Number deceased ______

Number of children ______ Number living ______ Number deceased ______

List ages of children ______ 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.)

______

______

______

______

Social History

☐ Never Married ☐ Married ☐ Domestic Partner (Spouse/Partner Name: ________________________) # Kids _______
☐ Divorced ☐ Separated ☐Widowed Spouse/Significant Other (Circle One): Alive / Deceased Age/Deceased _____
Spouse/Significant Other Major Illness _______________
Education (Highest Level of Education Completed):
Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School __________________________________
Are you working? ☐ Yes What do you do? ______________ # Hours Worked/Average per week ____________
☐ No ☐ Retired ☐ Disabled
Do you drink caffeinated beverages? ☐ Yes ☐ No Drinks per Day ________________
Do you use tobacco products? ☐ Never ☐ Yes Packs per Day ______ Years Smoked ______ Date Quit _______
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff
Do you drink alcohol? ☐ Yes ☐ No Drinks per Day ___________ Drinks per Week ___________
Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week ________
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No Type ________________ Amount per week ___________________
Do you get enough sleep at night? ☐ Yes ☐ No
Do you wake up feeling rested? ☐ Yes ☐ No
Are you sexually active? ☐ 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:	

PLACE PATIENT LABEL HERE