DO NOT MAIL: BRING FORM DAY OF APPOINTMENT

Carolina Arthritis Center

History Form

Last Name ______________________ First Name ______________________ MI ______
Age __________ Date of Birth ______________________ Race ______________________ Sex __________
Referred By: ______________________ Primary Care Physician ______________________
Reason for Today's Visit (Chief Complaint) ______________________

____

____

Past Medical History

Illnesses: ______________________ ______________________ Surgeries: ______________________

Medications: include name and dosage, over the counter/herbals; attach additional pages if necessary.

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________
6) ______________________
7) ______________________
8) ______________________
9) ______________________
10) ______________________
11) ______________________
12) ______________________
13) ______________________
14) ______________________
15) ______________________

Allergies: include name of medication and reaction.

____

History of Blood Transfusion: Yes No (circle one)

Social History:

1) Alcohol: Beer: __________ Wine: __________ Liquor: __________
2) Tobacco: Cigarettes: __________ Cigars: __________ Chewing Tobacco: __________
3) IV Drug Use / Recreational Drug Use : Yes No (circle one)

Occupational History: Current Job ______________________
Disability : Yes No Applying for Disability : Yes No

Family History:

1) Marital Status*: Single Married Divorced (* answer optional)
2) Number of Children*: __________

Arthritis Diseases in Family: Yes No
If yes, who and what type of Arthritis: ______________________

____

Healthcare Maintenance:

1) Last Chest X-ray: ______________________
2) Mammogram: ______________________
3) PAP/pelvic : ______________________
4) PSA/prostate exam : ______________________
5) Colonoscopy/sigmoidoscopy : ______________________
6) PPD (skin test TB) : ______________________
7) Labwork : ______________________

Patient Signature : ______________________ Date : ______________________

Over →

Review of Systems : Check those that apply

Musculoskeletal:
Yes No Have you seen a Orthopedist or Rheumatologist?
Previous arthritis diagnosis?
____
____
Joint Pain ?
____________________ Which Joints?
____
Joint Swelling ?
____________________ Which Joints?
____
Stiffness?
a) When : AM PM All Day
b) How long ____________________
c) Improves with Rest ______________
d) Improves with Activity ___________
e) Improves with Medication ________
_____ Muscle Pain
_____ Muscle Weakness
Spine
_____ Neck Pain
_____ Mid-Back Pain
_____ Low Back Pain
_____ Sacroiliac Pain
_____ Tendonitis
_____ Bursitis
_____ Gout
_____ Other

General:
_____ Fever
_____ Weight Change
_____ Insomnia
_____ Fatigue/weakness
_____ Other

HEENT (head, eyes, ears, nose, throat):
Yes No Have you seen an ENT or Allergy specialist?
_____ Hair Loss
_____ Dry Eyes
_____ Dry Mouth
_____ Sinusitis
_____ Recurrent Mouth Ulcers
_____ Headache
_____ Visual Change
_____ Red or Pink Eye
_____ Tongue Pain with Chewing
_____ Other

Lungs :
Yes No Have you seen a Lung specialist?
_____ Shortness of Breath
_____ Fluid around the Lungs
_____ Asthma, Wheezing
_____ Cough
_____ Pleurisy
_____ Tuberculosis
_____ Other

Heart and Circulation :
Yes No Have you seen a Heart specialist?
_____ Cold Hands and Feet that turns colors
_____ Ulcers Hands/Feet
_____ Chest Pain
_____ High Blood Pressure
_____ Irregular Heart Rhythm
_____ Heart Attack / Angina
_____ Fluid around Heart (pericardial effusion)
_____ Blood Clot in Legs or Lungs (DVT/PE)
_____ Other

Skin :
Yes No Have you seen a Skin specialist?
_____ Rash
_____ Psoriasis
_____ Tick Bite or Lyme Disease
_____ Sensitivity to Light
_____ Other

Gastrointestinal :
Yes No Have you seen a GI specialist?
_____ Fluid in Abdomen (ascites)
_____ Trouble Swallowing
_____ Ulcer Disease
_____ Reflux Disease
_____ Diarrhea (requiring Rx with antibiotics)
_____ Liver Disease (hepatitis)
_____ Ulcerative Colitis
_____ Crohns Disease
_____ Irritable Bowel Syndrome
_____ Blood in Stools
_____ Other

Genitourinary / Renal :
Yes No Have you seen a Kidney specialist?
Yes No Are you Pregnant?
________________ Date of Last Period
Yes No Are you Menopausal?
_____________________ Date of Onset
_____ Sexually Transmitted Diseases (GC, Clamydia, Pelvic Inflammatory Disease, HIV)
_____ Miscarriages
_____ Kidney Stones
_____ Urinary Tract Infection
_____ Urethritis (recurrent)
_____ Prostatitis / Impotence
_____ Blood in Urine (hematuria)
_____ Other

Neurological :
Yes No Have you seen a Neurologist?
_____ Numbness / Tingling
_____ Seizure
_____ Stroke (CVA)
_____ Other

Psychiatric :
Yes No Have you seen a Psychiatrist/ Psychologist?
_____ Depression
_____ Anxiety
_____ Other

Hematologic / Lymphatic :
Yes No Have you seen a Blood specialist?
_____ Cancer
_____ Enlarged Lymph Glands
_____ Anemia
_____ a) hemolytic
_____ b) iron deficiency
_____ c) B_{12} deficiency
_____ Low White Blood Cell Count
_____ Low Platelets (blood clotting problems)
_____ Other

Endocrine :
Yes No Have you seen a Endocrinologist?
_____ Thyroid Disease
_____ Diabetes
_____ Osteoporosis / Osteopenia
_____ Fracture
_____ Other

Over →