



The Seattle Arthritis Clinic

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PATIENT HISTORY FORM

Date of first appointment: / / Time of appointment: Birthplace:
MONTH DAY YEAR

Name: Birthdate: / /
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: Age: Sex: F M
STREET APT#

 Telephone: Home ()
CITY STATE ZIP Work ()

MARITAL STATUS: Never Married Married Divorced Separated Widowed Partnered

Spouse/Significant Other: Alive/Age Deceased/Age Major Illnesses

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School

Occupation Number of hours worked/average per week

Referred here by: (check one) Self Family Friend Doctor Other Health Professional

Name of person making referral:

The name of the physician providing your primary medical care:

Do you have an orthopedic surgeon? Yes No If yes, Name:

Describe briefly your present symptoms:

Date symptoms began (approximate):

Diagnosis:

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 problem:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself	Relative Name/Relationship	Yourself	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions:

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

Example:

LEFT RIGHT LEFT RIGHT

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.

Patient's Name Date Physician Initials

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____ / ____ / ____ Date of last eye exam ____ / ____ / ____ Date of last chest x-ray ____ / ____ / ____

Date of last Tuberculosis Test ____ / ____ / ____ Date of last bone densitometry ____ / ____ / ____

Constitutional

- Recent weight gain
amount _____
- Recent weight loss
amount _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

Ears–Nose–Mouth–Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

Gastrointestinal

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

Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? Yes No

How many days apart? _____

Date of last period? ____ / ____ / ____

Date of last pap? ____ / ____ / ____

Bleeding after menopause? Yes No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling

List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

Neurological System

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

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/when _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
 Cups/glasses per day? _____

Do you smoke? Yes No Past – How long ago? _____

Do you drink alcohol? Yes No Number per week _____

Has anyone ever told you to cut down on your drinking?
 Yes No

Do you use drugs for reasons that are not medical? Yes No
 If yes, please list: _____

Do you exercise regularly? Yes No
 Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

PAST MEDICAL HISTORY

Do you now or have you ever had: (*check if "yes"*)

Cancer Heart problems Asthma
 Goiter Leukemia Stroke
 Cataracts Diabetes Epilepsy
 Nervous breakdown Stomach ulcers Rheumatic fever
 Bad headaches Jaundice Colitis
 Kidney disease Pneumonia Psoriasis
 Anemia HIV/AIDS High Blood Pressure
 Emphysema Glaucoma Tuberculosis

Other significant illness (please list) _____

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

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? No Yes Describe: _____

Any other serious injuries? No Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

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

- Cancer _____ Heart disease _____ Rheumatic fever _____ Tuberculosis _____
- Leukemia _____ High blood pressure _____ Epilepsy _____ Diabetes _____
- Stroke _____ Bleeding tendency _____ Asthma _____ Goiter _____
- Colitis _____ Alcoholism _____ Psoriasis _____

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 medication, 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	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
<p>Circle any you have taken in the past</p> <p> Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) </p>					
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ProSORBA Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

Have you participated in any clinical trials for new medications? Yes No

If yes, list: _____

BRIEF PATIENT HEALTH QUESTIONNAIRE

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name _____ Age _____ Sex: ___M___F Today's Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
a. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual (which?).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Questions about anxiety.

	NO	YES
a. In the <u>last 4 weeks</u> , have you had an anxiety attack – suddenly feeling fear or panic?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you checked NO, go to question #3.</i>		
b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do some of these attacks come <u>suddenly out of the blue</u> – that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>
d. Do these attacks bother you a lot or are you worried about having another attack?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? (circle which symptoms).....	<input type="checkbox"/>	<input type="checkbox"/>

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All Somewhat Difficult Very Difficult Extremely Difficult

4. In the **last 4 weeks**, how much have you been bothered by any of the following problems?

	Not Bothered	Bothered A Little	Bothered A Lot
a. Worrying about your health.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Your weight or how you look.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Little or no sexual desire or pleasure during sex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. The stress of taking care of children, parents, or other family members.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Stress at work outside of the home or at school.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Financial problems or worries.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Having no one to turn to when you have a problem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Something bad that happened <u>recently</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Thinking or dreaming about something terrible that happened to you in <u>the past</u> – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. In the **last year**, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? NO YES

6. What is the most stressful thing in your life right now? _____

7. Are you taking any medicine for anxiety, depression or stress? NO YES

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?
<i>If your answer to this question is "NO", you have completed this section – please do not answer the questions below.</i>		
2. In the past 12 months:		
<input type="checkbox"/>	<input type="checkbox"/>	a. Did you need to drink more in order to get the same effect that you got when you first started drinking?
<input type="checkbox"/>	<input type="checkbox"/>	b. When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms (If yes to either, please check "YES").
<input type="checkbox"/>	<input type="checkbox"/>	c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?
<input type="checkbox"/>	<input type="checkbox"/>	d. Have you tried to reduce or stop drinking alcohol but failed?
<input type="checkbox"/>	<input type="checkbox"/>	e. On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?
<input type="checkbox"/>	<input type="checkbox"/>	f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
<input type="checkbox"/>	<input type="checkbox"/>	g. Have you continued to drink even though you knew that it caused you problems?