HC HIGHLAND CLINIC

FAX FORM TO 4451

DATE:___________

PATIENT HISTORY FORM
RHEUMATOLOGY

PCP / REFERRING MD
____

Name:____DOB:_________________________Age:______

Reason for Visit:____

Medical History:

Have you ever had?

- ☐ None
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Blood Clot
- ☐ Diabetes
- ☐ Hypertension
- ☐ Stroke
- ☐ Seizure
- ☐ Neuropathy
- ☐ Depression
- ☐ Hallucination
- ☐ Anemia
- ☐ Platelet disorder
- ☐ Blood transfusion
- ☐ Miscarriage
- ☐ Other___________________________________
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Sjorgren's
- ☐ Raynaud's
- ☐ Scleroderma
- ☐ Fibromyalgia
- ☐ Psoriasis
- ☐ Sarcoidosis
- ☐ Stomach/Intestine Blood
- ☐ Celiac Disease
- ☐ Crohn's/Ulcerative Colitis
- ☐ Lyme Disease
- ☐ Ankylosing Spondylitis
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease

Surgical History:

- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Bone or Joint
- ☐ Wisdom Teeth
- ☐ Gallbladder
- ☐ Heart Bypass
- ☐ Colonoscopy
- ☐ Cosmetic Surgery
- ☐ Organ Transplant
- ☐ Other:_____________
- ☐ Other:_____________
- ☐ Other:_____________
- ☐ Other:_____________

Social History:

Occupation:_______________
Disability: Yes No
Use or Ever Use?
Tobacco: Yes No Quit
Type______________
How much________
How long_________
Alcohol: Yes No Quit
Type______________
How much________
How long_________
Illicit Drugs: Yes No Quit
Type______________
How much________
How long_________
☐ Tattoos: Yes No
Date of most recent_____
☐ Body Piercing Yes No
Date of most recent_____

Family History: *Please indicate family member*

Father: Living/ Deceased Age:____ Health Problems:_______________________________________
Mother: Living/Deceased Age:____ Health Problems:_______________________________________
Brother: Living/ Deceased Age:____ Health Problems:_______________________________________
Brother: Living/Deceased Age:____ Health Problems:_______________________________________
Brother: Living/ Deceased Age:____ Health Problems:_______________________________________
Sister: Living/Deceased Age:____ Health Problems:_______________________________________
Sister: Living/ Deceased Age:____ Health Problems:_______________________________________
Sister: Living/Deceased Age:____ Health Problems:_______________________________________
Child: Living/ Deceased Age:____ Health Problems:_______________________________________
Child: Living/Deceased Age:____ Health Problems:_______________________________________
Child: Living/ Deceased Age:____ Health Problems:_______________________________________
Child: Living/Deceased Age:____ Health Problems:_______________________________________

Any family members known with reasonable certainty to have any of the following?

- ☐ Osteoarthritis
- ☐ Gout
- ☐ Psoriasis
- ☐ Thyroid Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Scleroderma
- ☐ Ulcerative Colitis
- ☐ Fibromyalgia
- ☐ Sarcoidosis
- ☐ Celiac Disease
- ☐ Sjogren's
- ☐ Ankylosing Spondylitits

Patient Name:____ Date:_________________________

ALLERGIES:

☐ NONE
☐ Medications

Medication________________________Reaction______________________Age at the Time______
Medication________________________Reaction______________________Age at the Time______
Medication________________________Reaction______________________Age at the Time______
Medication________________________Reaction______________________Age at the Time______
Medication________________________Reaction______________________Age at the Time______
Medication________________________Reaction______________________Age at the Time______

☐ Latex

Current Medications: *(prescription, over-the-counter, herb or supplement)*
Drug Name Dose/Strength How you take it (for example, 1 a day, 2 a day, etc)

☐ NONE

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Review of Systems: Do you have?

☐ Fatigue	☐ Vision Changes	☐ Irregular Heartbeat	☐ Blood in Stool
☐ Fever	☐ Dry gritty eyes	☐ Shortness of Breath	☐ Black Tarry Stool
☐ Chills	☐ Dry Mouth	☐ Cough	☐ Abdominal Pain
☐ Weight Gain	☐ Swollen Facial Glands	☐ Heartburn	☐ Blood in urine
☐ Weight Loss	☐ Difficulty swallowing	☐ Nausea	☐ Painful urination
☐ Night Sweats	☐ Hoarseness	☐ Vomiting	☐ Numbness or tingling
☐ Headaches	☐ Chest Pain	☐ Watery Stool	☐ Extremity swelling
☐ Depression	☐ Anxiety	☐ Memory Loss	☐ Hallucinations
☐ Skin Rash	☐ Tight Skin	☐ Mouth or nose ulcer	☐ Genital ulcer or discharge
			☐ LMP(females)_________

☐ Do you sunburn more easily than you used to? ☐ Do your fingers turn colors when holding a cold glass?

☐ Muscle pain ☐ Muscle Weakness

Resulting limitations?____
____

☐ Painful joints ☐ Swollen joints

Which ones?____
____

For how long?____
____