Washington University in St. Louis Physicians

Welcome!

Washington University Rheumatology

Medical History Form

Please complete all THREE pages of this form and bring it with you to your office visit.

Patient's Name _____ Date of First Appointment ___/___/___

Date of Birth ___/___/___ Age ___ Sex ☐ F ☐ M May we leave a message on your phone listed below? ☐ No ☐ Yes

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Name of Person Making Referral _____ Phone Number (___) _____ Fax (___) _____

Name of Primary Care Physician _____ Phone Number (___) _____ Fax (___) _____

PRESENT SYMPTOMS AND/OR REASON FOR THIS APPOINTMENT

Describe Symptoms _____

Approximate Date Symptoms Began _____

Diagnosis Given _____

Have you seen others for this problem? ☐ No ☐ Yes *If yes,* list below.

Name _____ Name _____

Name _____ Name _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY At any time, have you or a BLOOD relative had any of the following?

	Yourself	Relationship (e.g., sister)		Yourself	Relationship (e.g., sister)
Osteoarthritis	☐ No ☐ Yes	_____	**Rheumatoid Arthritis**	☐ No ☐ Yes	_____
Gout	☐ No ☐ Yes	_____	**Ankylosing Spondylitis**	☐ No ☐ Yes	_____
Childhood Arthritis	☐ No ☐ Yes	_____	**Fibromyalgia**	☐ No ☐ Yes	_____
Osteoporosis	☐ No ☐ Yes	_____	**Arthritis** *(type unknown)*	☐ No ☐ Yes	_____
Lupus or "SLE"	☐ No ☐ Yes	_____	**Other** _____	☐ No ☐ Yes	_____

PREVIOUS TREATMENT

Check all that apply and describe the treatment.

☐ Medication _____

_____

☐ Injections _____

_____

☐ Physical Therapy _____

_____

☐ Surgery _____

_____

☐ Other _____

_____

_____

_____

SURGERIES If you need more room, please bring a list on a separate sheet of paper.

Type of Surgery	Year	Surgeon/Location

Any Previous Fractures? ☐ No ☐ Yes If yes, describe _____

Any Serious Injuries? ☐ No ☐ Yes If yes, describe _____

SYMPTOMS Check each symptom you have had.

- ☐ Recent Weight Loss/Gain
- ☐ Fever/Chills
- ☐ Fatigue/Tiredness
- ☐ Problems Sleeping
- ☐ Night Sweats
- ☐ Hair Loss
- ☐ Problems Hearing
- ☐ Numbness/Tingling
- ☐ Skin Rash/Sun Rash
- ☐ Dry Eyes
- ☐ Dry Mouth
- ☐ Problems Swallowing
- ☐ Eyes Sensitive to Light
- ☐ Red/Itchy/Burning Eyes
- ☐ Double/Blurred Vision
- ☐ Nose Bleeds
- ☐ Cough
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Dizziness/Fainting
- ☐ Shortness of Breath
- ☐ Coughing up Blood
- ☐ Swollen/Tender Glands
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood/Mucous in Stool
- ☐ Stomach Pain/Ulcer
- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Sores in Mouth, Nose, Vagina, Penis
- ☐ Headaches
- ☐ Tightness of Skin
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Muscle Spasms/Tenderness
- ☐ Morning Stiffness
- ☐ Night Pain
- ☐ Color Changes of Hands or Feet with Cold

☐ Joint Problems (List joints affected within the last 6 months): _____

MEDICAL CONDITIONS Check if YOU have been diagnosed with or have the following. Give year of diagnosis, if known.

☐ Cancer_____ ☐ Heart Problems _____ ☐ Asthma _____ ☐ Goiter _____

☐ Leukemia _____ ☐ Heart Murmur _____ ☐ Diabetes _____ ☐ Hypothyroidism _____

☐ Epilepsy/Seizures_____ ☐ Rheumatic Fever _____ ☐ Stomach Ulcers _____ ☐ Psoriasis_____

☐ Migraine Headaches_____ ☐ Stroke _____ ☐ Colitis_____ ☐ Rosacea_____

☐ Depression Anxiety_____ ☐ High Blood Pressure _____ ☐ Chronic Bronchitis _____ ☐ HIV/AIDS_____

☐ Chronic Fatigue _____ ☐ High Cholesterol _____ ☐ Emphysema _____ ☐ Cataracts_____

☐ Muscular Dystrophy _____ ☐ Jaundice/Hepatitis _____ ☐ Tuberculosis _____ ☐ Iritis/Eye Inflammation _____

☐ Anemia _____ ☐ Kidney Disease _____ ☐ Pneumonia _____ ☐ Dentures _____

☐ Blood Clots_____ ☐ Miscarriage_____ ☐ Sinus Problems _____ ☐ Hearing Aid _____

☐ Other Significant Illness (Please list): _____

PERSONAL HISTORY

Do you drink caffeinated coffee/tea/soda? ☐ Never ☐ Yes If yes, list _____ cups per day

Do you drink alcohol? ☐ Never ☐ Yes *If yes,* how much?____ cans/cups per week (1 drink = 4 oz wine, 12 oz beer, 1.5 oz hard liquor

Drink(s) of choice _____ ☐ Quit

Do you use street drugs? ☐ Never ☐ Yes If yes, list kind and amount_____ ☐ Quit

Do you use tobacco? ☐ Never ☐ Yes (if yes, answer ***"Present Use"*** below) ☐ Quit (If quit, answer ***"Past Use"*** below

Present Use:

☐ Cigarettes ____ per day Age Started____ for ____ years

☐ Cigars_____ per day Age Started____ for ____ years

Past Use:

☐ Cigarettes ____ per day Age Started____ for ____ years

☐ Cigars_____ per day Age Started____ for ____ years

Occupation_____ Average number of hours worked per week_____ ☐ Retired

Are you involved in a medically related lawsuit? ☐ No ☐ Yes **Are you applying for disability?** ☐ No ☐ Yes

Number of people in your household_____ Relationship_____ Age____ Relationship_____ Age____

Relationship_____ Age____ Relationship_____ Age____ Relationship_____ Age____

FAMILY HISTORY

	If Alive Age	If Deceased Age at Death	Major Medical Problems or Cause of Death		If Alive Age	If Deceased Age at Death	Major Medical Problems or Cause of Death
Mother				Father			
Sister				Brother			
Sister				Brother			
Sister				Brother			
Child				Child			
Child				Child			

Have any blood relatives had any of the following illnesses? Give relationship(s) to you.

Condition	Relationship to You	Condition	Relationship to You	Condition	Relationship to You
☐ Cancer		☐ High Blood Pressure		☐ Asthma	
☐ Leukemia		☐ Bleeding Tendency		☐ Goiter	
☐ Stroke		☐ Muscular Dystrophy		☐ Diabetes	
☐ Colitis		☐ Tuberculosis			
☐ Heart Disease		☐ Epilepsy			

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date