

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) _____ 4) _____ 10) _____
2) _____ 5) _____ 11) _____
3) _____ 6) _____ 12) _____
7) _____ 13) _____
8) _____ 14) _____
9) _____ 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: _____ 5) Colonoscopy/sigmoidoscopy : _____
2) Mammogram: _____ 6) PPD (skin test TB) : _____
3) PAP/pelvic : _____ 7) Labwork : _____
4) PSA/prostate exam : _____

Patient Signature : _____ Date : _____

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, Chlamydia, 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) B₁₂ 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

