INOVA™

RHEUMATOLOGY MEDICAL HISTORY

Name _____ Date of Visit_____
Last Four Digits Social Security Number_____ Birth date ___/____/____
Do you have trouble hearing or understanding information over the phone? ___ Yes ____ No
What is your preferred language? _____
Race □Asian □Black or African American □Native American □White / Caucasian
□Other:_____
Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____
Religion: Do you identify with a particular religion? If yes, please note: _____

Presenting Problem(s)
Please explain what you are being seen for today: _____
_____

Referring Doctor _____ Specialty _____
Phone # _____ Fax # _____

Primary Care Doctor _____ Specialty _____
Phone # _____ Fax # _____

III. Medical History

A. Medical Problems – Have you ever been diagnosed with any of the following?

□Heart Disease
- □Heart Attack (MI) □Congestive Heart Failure □Arrhythmia
- □Atrial fibrillation □Angina □Coronary artery disease
- □Ischemic heart disease □Cardiomyopathy □Pericarditis
- □Pericardial effusion □Rheumatic fever □Heart murmur
- □Valvular Heart Disease (Mitral regurgitation, Mitral stenosis, Aortic insufficiency, Aortic stenosis)
- □Other: _____

□Lung Disease
- □Emphysema □COPD □Asthma
- □Pulmonary fibrosis □Interstitial lung disease □Sleep apnea
- □Pleural effusion □Pulmonary hypertension □Sarcoidosis
- □Pleurisy
- □Other: _____

□Kidney Disease
- □Nephritis □Renal insufficiency □Renal failure
- □Kidney stones □Other: _____

□Liver Disease
- □Hepatitis □Cirrhosis □Other: _____

□GI Disease
- □Reflux/Esophagitis □GI bleed □Irritable Bowel Syndrome
- □Ulcer Disease □Diverticular disease □Gastric ulcer
- □Duodenal ulcer □Diverticulosis □Diverticulitis
- □Colitis □Gallbladder Disease (gall stones)
- □Other: _____

□Edema
□Cancer
□Colon □Breast □Lung
□Stomach □Brain □Prostate
□Pancreatic □Ovarian □Cervical
□Uterine □Testicular □Bone
□Lymphoma □Leukemia □Other: _____
□ Diabetes Type: _____
□Thyroid Disorder Type: _____
□Blood Disorder
□Anemia □Low white count □Low platelet count
□Other: _____
□Neurological or Muscular Disorder
□Stroke/TIA □Seizures □Migraine headaches
□Multiple Sclerosis □Neuropathy □Carpal Tunnel Syndrome
□Polymyositis □Muscular Dystrophy □Other: _____
□High Blood Pressure
□Elevated Cholesterol or Other Hyperlipidemia
□Blood Clot
□Deep Venous Thrombosis □Pulmonary Embolism □Other: _____
□Serious Infection(s)
□Pneumonia □Endocarditis □Tuberculosis
□Septicemia □Pyelonephritis □Abscess
□Other: _____
□Psychiatric Disorder
□Anxiety □Depression □Bipolar disorder
□Schizophrenia □Other: _____
□Arthritis
□Degenerative Joint Disease □Osteoarthritis □Rheumatoid Arthritis
□Lupus □Gout □Pseudogout
□Connective Tissue Disease □Spondyloarthopathy □Ankylosing Spondylitis
□Scleroderma □Sjogren's syndrome
□Polymyalgia Rheumatica (PMR) □Other: _____
□Sexually Transmitted Disease:
□Gonorrhea □Chlamydia □Syphilis
□Other: _____
□Immune Deficiencies Type: _____

□Osteoporosis or Osteopenia Have you ever had a bone density test? _____
If yes, when: _____ Where: _____

B. Surgeries – Please list any procedures you have had including orthopedic procedures. Also include the date. Please attach a separate sheet of paper if more room is necessary.

Procedure: _____ Date: _____
Procedure: _____ Date: _____

Last Name: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

C. Other Hospitalizations – Please attach a separate sheet of paper if more room is necessary.

Please list any other hospitalizations, reason for hospitalization, approximate date and which hospital:

Reason: _____ Date: _____ Hospital?: _____

Reason: _____ Date: _____ Hospital?: _____

Reason: _____ Date: _____ Hospital?: _____

Reason: _____ Date: _____ Hospital?: _____

Reason: _____ Date: _____ Hospital?: _____

D. Serious Injuries – Please attach a separate sheet of paper if more room is necessary.

Please list any serious injuries especially musculoskeletal injuries, include approximate date:

Injury: _____ Date: _____

Injury: _____ Date: _____

Current Medications:

Name	Dose	Times/Day	Reason	Start Date

Please include prescription and over the counter medications, as well as supplements and vitamins. If you have a medication list, please attach. If you do not have a medication list, please bring your medication bottles with you to your first appointment.

Last Name: _____ Date: _____

Allergies: ___None

To Medications

Name _____ Type of Reaction _____ Mild/Moderate/Severe

Name _____ Type of Reaction _____ Mild/Moderate/Severe

IV. Family History

Has any BLOOD relative ever been diagnosed with any of the following, please list relationship:

Arthritic Disorder (please list type if known): □ No □ Yes

Lupus: □ No □ Yes Connective Tissue Disease: □ No □ Yes

Gout: □ No □ Yes Osteoporosis: □ No □ Yes

Cancer: □ No □ Yes type:_____

Other: _____

V. Social History

Marital Status _____ Who do you live with? _____

Highest Education Level _____ Occupation _____

Do you have a support system at home? _____ Who? _____

Have you ever smoked? _____ Do you currently? _____ If yes how much and how long? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use illicit/street drugs? _____ If yes, which ones? _____

Do you drive? _____ Do you exercise regularly?_____ Do you have any tattoos? _____

Have you had any recent falls at home? _____ Can you care for yourself? _____

Do you have any concerns with any self-care or activities of daily living? _____

Do you require aids or assistive devices for mobility? _____

Can you walk 100 yards? _____

VI. Review of Systems – Please indicate if you have had any trouble with the following over the past 5 years:

Hair Loss (Alopecia) □ No □ Yes If Yes: □Generalized □Thinning □Patchy

Oral or Nasal Ulcers □ No □ Yes

Rash: □ No □ Yes

Type: _____ Area(s) of involvement: _____ When: _____

Photosensitivity (any rash with sun exposure) □ No □ Yes Psoriasis: □ No □ Yes

Raynauds – Hands, fingers, feet or toes turn blue or white with cold exposure □ No □ Yes

Sicca Sx – severe dry eyes or dry mouth: □ No □ Yes

Low or abnormal blood count

Anemia: □ No □ Yes Low White Blood Count: □ No □ Yes

Low Platelet Count: □ No □ Yes

Pleurisy or Pericarditis (inflammation of the lining of the lungs or heart): □ No □ Yes

Inflammatory Eye Disorder

Iritis: □ No □ Yes Uveitis: □ No □ Yes Conjunctivitis: □ No □ Yes

Last Name: _____ Date: _____

Hematuria or Proteinuria (history of blood or protein in urine): □ No □ Yes

Blood clot : □ No □ Yes

Gastrointestinal Symptoms

Abdominal Pain: □ No □ Yes Nausea: □ No □ Yes Vomiting: □ No □ Yes

Diarrhea: □ No □ Yes GI Bleeding: □ No □ Yes Colitis: □ No □ Yes

Difficulty swallowing: □ No □ Yes

Neurological symptoms

Headaches: □ No □ Yes Visual symptoms: □ No □ Yes

Numbness or tingling in extremities *(parasthesias)*: □ No □ Yes

Cramping in jaw muscles while chewing *(jaw claudication)*: □ No □ Yes

Pain in jaw *(TMJ; Temporomandibular joint)* □ No □ Yes

Difficulty sleeping: (*Sleep disturbance of any kind)* □ No □ Yes

Fever *(temperature elevatio*n), chills, sweating: □ No □ Yes

Loss of appetite: □ No □ Yes Unintentional weight loss: □ No □ Yes

Fatigue: □ No □ Yes

Respiratory Symptoms

Shortness of breath: □ No □ Yes Cough – dry or productive: □ No □ Yes

Coughing up blood: □ No □ Yes Chest pain with breathing (pleuritic pain): □ No □ Yes

Musculoskeletal Symptoms

Joint Pain: □ No □ Yes Joint Stiffness: □ No □ Yes Joint Swelling: □ No □ Yes

Joint loss of motion: □ No □ Yes Back Pain: □ No □ Yes Muscle Pain: □ No □ Yes

Muscle weakness: □ No □ Yes Nodules, lumps or bumps under the skin: □ No □ Yes

Women Only

Pregnancies: Are you currently pregnant? □Yes □No _____ weeks

_____ Number of pregnancies

_____ Number of deliveries

_____ Number of miscarriages

_____ Number of abortions

Have you had any 2nd or 3rd trimester miscarriages? □Yes □No

Do you use birth control? □Yes □No

Do you plan to have anymore children? □Yes □No

Age of menopause (if applicable) _____