Atrium Health Rheumatology Patient History Form

Date _____/_____/_____

Name _____
Last First M.I.

Age _____ Sex M/F Race _____ Preferred Language _____

Briefly describe your symptoms:

_____

_____

_____

When did your symptoms begin? _____

What do you think caused it? _____

What prescription medications have you tried? _____

_____

_____

What over the counter medications/alternative treatments have you tried? _____

_____

_____

Social History

Occupation_____ Where do you work? _____

Highest level of education: _____

Marital Status (circle one): Single Married Separated Divorced Widow(er)

Number of children: _____

Do you use any tobacco products? Yes No _____ Do you drink alcohol? Yes No _____

Are you on disability? Yes No Year _____ Have you applied for disability? Yes No

Do you participate in regular physical exercise? How often? _____

What hobbies do you enjoy? _____

Past Medical History (Check if "yes")

__ High Blood Pressure
__ Heart Disease
__ High Cholesterol
__ Diabetes Mellitus
__ Thyroid Disease
__ Cancer
__ Anemia
__ Blood Clots
__ Sinusitis
__ Asthma
__ Rheumatoid Arthritis
__ Lupus
__ Emphysema/COPD
__ Pneumonia
__ Acid Reflux/GERD
__ Stomach Ulcer
__ Irritable Bowel Syndrome
__ Crohn's/Ulcerative Colitis
__ Hepatitis/Liver Disease
__ Migraine Headaches
__ Epilepsy/Seizure Disorder
__ Stroke/TIA
__ Nerve Disease? Neuropathy
__ Gout
__ Osteoarthritis
__ Psoriasis
__ Iritis/Scleritis/Uveitis
__ Dry Eyes/Dry Mouth
__ Raynaud's Phenomenon
__ Muscle Disease
__ Broken Bone(s)
__ Kidney Disease
__ Kidney Stone
__ Psychiatric Disorder
__ Anxiety/Depression
__ Drug or Alcohol Abuse
__ Fibromyalgia
__ Osteoporosis
__ Insomnia
__ Obstructive sleep apnea

*Continued on other side

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Prior Hospitalizations/Operations ☐ No

Surgery/Hospitalizations

Surgery and Date	Surgery and Date
1.	5.
2.	6.
3.	7.
4.	8.

Current Medications ☐ No Current Meds

Name of Drug	Dose (strength and how often)	How long have you been on this?

Drug Allergies:

_____

Family History

Do you know any blood relatives that has or had any of the following?

	Relative Name/Relationship		Relative Name/Relationship
Arthritis (unknown type)		Lupus or SLE	
Osteoarthritis		Rheumatoid Arthritis	
Gout		Ankylosing Spondylitis	
Childhood Arthritis		Osteoporosis	
Psoriasis/Psoriatic Arthritis		Sjogren's Syndrome	

Notes/Additional History

_____

_____

_____