Health History for UW Medical Center – Northwest Seattle Arthritis Clinic

Name: Last _____ **First** _____ **MI** _____ **Date:** _____

Birthdate: _____ **Location:** _____ **E-Mail :** _____

REASON FOR VISIT: _____ **Gender:** _____

Referring Provider: _____ **Preferred Pronoun:** _____

Primary Care Provider _____ **Preferred Pharmacy:** _____

Allergies: ☐ No Allergies	**Medication or Substance**	**Reaction**

Current Medications: OR ☐ See Attached List	**Label - Name**	**Dose**	**Frequency**

Rheumatologic (Arthritis) History

Describe your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment(s) for this problem. (Please include physical therapy, surgery, and injections. Medications should be listed on the medications and supplements section on the first page.)

_____

_____

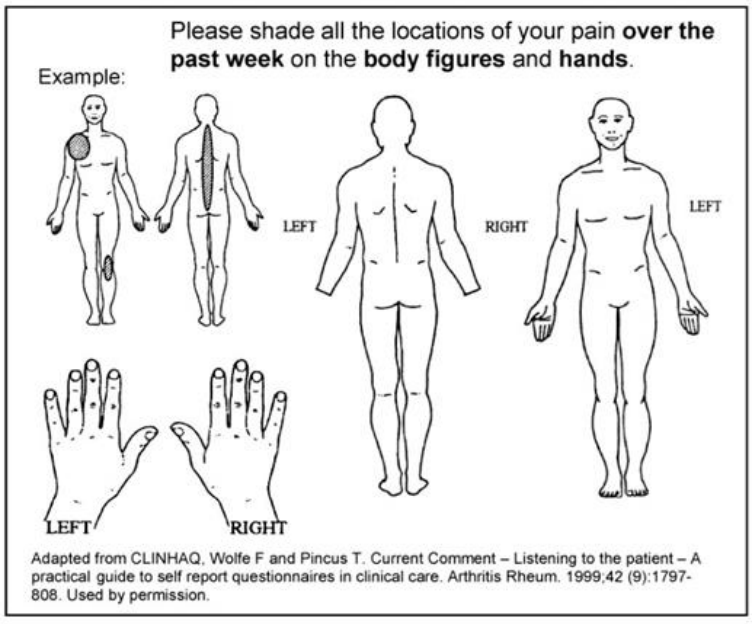
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

_____



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

PLACE PATIENT LABEL HERE

Rheumatologic (Arthritis) History (cont.)

Please check (✓) the **ONE** best answer for **your abilities** at this time:

At this moment, are you able to:	Without Any Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of the car, bus, train or airplane?	0	1	2	3
i. Walk two miles?	0	1	2	3
j. Participate in sports and games as you would like?	0	1	2	3
k. Get a good night's sleep?	0	1	2	3
l. Deal with feelings of anxiety or nervousness?	0	1	2	3
m. Deal with feelings of depression or "blue"?	0	1	2	3

FN 0-10

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3
25=8.3
11=3.7
26=8.7
12=4.0
27=9.0
13=4.3
28=9.3

PTGL 0-10

RAPID3 0-30

1. How much pain have you been in because of your condition **over the past week?** Please indicate below how severe your pain has been:

NO PAIN ○ 0 0.5 1 1.5 2 2.0 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 ○ 10 **PAIN AS BAD AS IT COULD BE**

2. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below **how you are doing**:

VERY WELL ○ 0 0.5 1 1.5 2 2.0 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 ○ 10 **VERY POORLY**

Screening

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

PLACE PATIENT LABEL HERE

Review of Systems (Current Symptoms) – Please check only if these are bothering you at this time

Constitutional:
- ☐ Fevers
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

Head/Eyes:
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Poor Vision
- ☐ Color Blindness
- ☐ Eye Redness

Ears/ Nose/ Mouth/ Throat:
- ☐ Hearing Loss
- ☐ Chronic Sinus Congestion
- ☐ Heavy Snoring
- ☐ Bad Teeth
- ☐ Oral Ulcers
- ☐ Nose Bleeds
- ☐ Dry Mouth

Respiratory (Lungs):
- ☐ Cough
- ☐ Shortness of Breath While Lying Flat
- ☐ Shortness of Breath With Exertion

Heart:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Color Changes of Hands & Feet in Cold

Genitourinary:
- ☐ Sexual Problems
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Leakage of Urine
- ☐ Genital Ulcers
- ☐ Penile Discharge
- ☐ Vaginal Discharge

Gastrointestinal:
- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/Indigestion
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Vomiting Blood
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Abdominal Swelling
- ☐ Trouble Swallowing
- ☐ Rectal Bleeding
- ☐ Other (Please list): _____

Muscle/ Bones:
- ☐ Chronic Pain
- ☐ Muscle Cramping
- ☐ Muscle Weakness
- ☐ Arthritis
- ☐ Muscle Wasting
- ☐ Morning Stiffness Lasting how long? _____min_____hrs
- ☐ Joint Swelling List joints affected in the last 6 months):

Neurological:
- ☐ Headaches
- ☐ Seizures (Epilepsy)
- ☐ Confusion
- ☐ Tremor (Shaking)
- ☐ Numbness
- ☐ Tingling
- ☐ Loss of sensation

Vascular:
- ☐ Blood Clots
- ☐ Varicose Veins

Skin:
- ☐ Rash
- ☐ Jaundice
- ☐ Itching
- ☐ Psoriasis

Psychosocial:
- ☐ Anxiety / Nerves
- ☐ Feeling Worthless
- ☐ Sexual Problems
- ☐ Sleep Problems
- ☐ Depression

Endocrine:
- ☐ Hot Flashes
- ☐ Intolerance to Heat
- ☐ Excessive Thirst
- ☐ Intolerance to Cold

Blood/ Lymph:
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Easy Bleeding

Specialty Medical History — Please check box for those conditions you have now or have ever had.

- ☐ Ankylosing Spondylitis
- ☐ Antiphospholipid Syndrome
- ☐ Behcet's Disease
- ☐ Bursitis
- ☐ De Quervain's Tendinosis
- ☐ Dermatomyositis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Inflammatory Bowel Disease
- ☐ Interstitial Lung Disease
- ☐ Kidney Disease
- ☐ Low Back Pain
- ☐ Lupus
- ☐ Myopathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Plantar Fasciitis
- ☐ Polymyalgia Rheumatica
- ☐ Polymyositis
- ☐ Pseudogout
- ☐ Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Scleroderma
- ☐ Shoulder Problem
- ☐ Sjogren's Syndrome
- ☐ Spinal Stenosis
- ☐ Spondyloarthropathy
- ☐ Tendonitis
- ☐ Trigger Finger
- ☐ Uveitis
- ☐ Vasculitis

PLACE PATIENT LABEL HERE

Rheumatology Medications

	Methotrexate	Leflunomide	Humira	Enbrel	Actemra	Benlysta	Cimzia	Orencia	Remicade	Rituxan	Simponi	Simponi Aria	Cosentyx	Stelara	Hydroxychloroquine	Otezla	Plaquenil	Sulfasalazine	Minocycline	Kineret	Anti-Inflammatories	Cytoxan	Prednisone					Comments
Currently Taking																												
Previously Taken																												
Helpful																												
Not Helpful																												
Tolerated																												
Not Tolerated																												

General Medical History

Please check box for those conditions you have now or have ever had.

- ☐ No Past Medical History
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding/ Clotting Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Emphysema
- ☐ Jaundice
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Heart Problems
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Lipid / Cholesterol
- ☐ Lung Disease
- ☐ Cataracts
- ☐ Leukemia
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Musculoskeletal
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ PPD
- ☐ Seizures
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Nervous Breakdown
- ☐ Stomach Ulcers
- ☐ Rheumatic Fever
- ☐
- ☐ Other (Please list and include any significant illness): _____

Surgical History

Please check box for any surgery you have had. Indicate the year (YYYY).

- ☐ No Past Surgical History
- ☐ Achilles Repair (____)
- ☐ Appendectomy (____)
- ☐ Back Surgery (____)
- ☐ Breast Surgery (____)
- ☐ CABG (____)
- ☐ Carpal Tunnel Release (___)
- ☐ Elbow Surgery (____)
- ☐ Foot Surgery (____)
- ☐ Fracture Surgery (____)
- ☐ Gall Bladder Surgery (____)
- ☐ Hand Surgery (____)
- ☐ Hip Surgery (____)
- ☐ Joint Replacement – Hip (____)
- ☐ Joint Replacement – Knee (____)
- ☐ Joint Replacement – Shoulder (____)
- ☐ Knee Surgery (____)
- ☐ Neck Surgery (____)
- ☐ Nephrectomy (____)
- ☐ Oophorectomy (____)
- ☐ Shoulder Surgery (____)
- ☐ Splenectomy (____)
- ☐ Wrist Surgery (____)

☐ Other (Please list): _____

_____

	Yes	No	
Any previous fractures?	☐	☐	Describe: _____
Any other serious injuries?	☐	☐	Describe: _____

Family History

PLACE PATIENT LABEL HERE

	Circle		Current age/ Age at death	Current heath/ Cause of death
Father	Alive	Deceased		
Mother	Alive	Deceased		
Sister	Alive	Deceased		
Brother	Alive	Deceased		
Maternal Grandmother	Alive	Deceased		
Maternal Grandfather	Alive	Deceased		
Paternal Grandmother	Alive	Deceased		
Paternal Grandfather	Alive	Deceased		

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____

List ages of children _____ Health of Children _____

_____ _____

_____ _____

****Type of Cancer or Disease:** _____

Family Rheumatologic (Arthritis) History

At any time has a blood relative had any of the following? (Check if "yes")

Relative Name/Relationship		Relative Name/Relationship	
	Arthritis (unknown type)		Lupus or "SLE"
	Osteoarthritis		Rheumatoid Arthritis
	Gout		Ankylosing Spondylitis
	Childhood arthritis		Osteoporosis
	Psoriasis		Inflammatory bowel disease

Alternative Medical History

Please list any Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Social History

☐ Never Married ☐ Married ☐ Domestic Partner (Spouse/Partner Name: _____) # Kids _____

PLACE PATIENT LABEL HERE

☐ Divorced ☐ Separated ☐Widowed Spouse/Significant Other (Circle One): Alive / Deceased Age/Deceased _____
Spouse/Significant Other Major Illness _____
Education (Highest Level of Education Completed):
Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School _____
Are you working? ☐ Yes What do you do? _____ # Hours Worked/Average per week _____
☐ No ☐ Retired ☐ Disabled
Do you drink caffeinated beverages? ☐ Yes ☐ No Drinks per Day _____
Do you use tobacco products? ☐ Never ☐ Yes Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff
Do you drink alcohol? ☐ Yes ☐ No Drinks per Day _____ Drinks per Week _____
Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No Type _____ Amount per week _____
Do you get enough sleep at night? ☐ Yes ☐ No
Do you wake up feeling rested? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female Birth Control _____

Health Maintenance

		Yes	No				
General	Colonoscopy	☐	☐	When:		Where:	
	Dexa/Bone Density	☐	☐	When:		Where:	
	Eye Exam	☐	☐	When:		Where:	
	Dental Exam	☐	☐	When:		Where:	
	Tuberculosis Test	☐	☐	When:		Where:	
	Last Mammogram			When:		Where:	
	Last Pap			When:		Where:	
	Last Prostate Exam			When:		Where:	
Vaccines	Influenza	☐	☐	When:		Where:	
	Pneumococcal	☐	☐	When:		Where:	
	Shingles	☐	☐	When:		Where:	
	Hepatitis B (or titer)	☐	☐	When:		Where:	

PLACE PATIENT LABEL HERE