RHEUMATOLOGY CLINIC OF HOUSTON
MEDICAL HISTORY QUESTIONNAIRE

Today's Date:_____________Date of Birth:____________Age:__________
Last name:_________________First__________________Middle________
Nickname:___________ Employed? ____Yes ____No ____On disability
Occupation:___________________Retired from:_____________________
I live at: _____Home _____College dormitory _____Assisted living home
Married status: _____Married _____Single ____Divorced _____Widowed
I live with: _____Spouse ______Family ____Parent _____Significant other

Tobacco Use: ____none ___packs per day for __years ____ex-smoker
Alcohol Use: ____none ____rarely ____socially ___more than 1 drink
I Illicit Drugs: ____none Yes, I use_______________________________

Primary Care Physician: __________________of _____________________
Who told you about our practice? __________________________________
WHAT ARE WE SEEING YOU FOR TODAY? _____________________
____
How long have you had these symptoms: ___________________________?
Was this from an injury? ___Yes ___No ____Uncertain
Date of injury (if applicable): __________ Location where the injury occurred: _________________Describe how the injury occurred: ________
___________________________ is this a work injury? ____No ____ Yes
Was it reported to the employer? ____Yes ____No

Treatment you've had for this problem: ___Pain pills (name)___________
____X-rays ____Bone scan ____MRI ____CT Scan ____Physical therapy
____ Steroid/cortisone shots----how many? ___ ____Hyalgan/Syn Visc shot
____Fluid taken out of joint ____Blood work ____Activity restriction
____Cast/ splint/ brace ____Crutches/ cane/ walker
____Chiropractic ____Surgery ____Heat ____Ice
I usually use: ____cane ____walker ____crutcher ____wheelchair

<u>HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?</u>

___Long-term steroid use (i.e. prednisone) ____Congenital hip dysphasia
___Osteomyelitis (bone infection) ____Rheumatoid arthritis
Of ________ (body part) in __year ____Juvenile RA

___Osteoporosis
___Gout
___Psoriatic arthritis
___Paget's disease
___Pathologic fractures________
___Reflex sympathetic dystrophy (RSD)
___Cancer
____Breast cancer Year diagnosed____
____Lung Year diagnosed____
____Prostate Year diagnosed____
Last PSA level (if known): _________________ When? ____________
____ Colon Year diagnosed____
____Primary bone cancer Year diagnosed____
___Diabetes, insulin dependent
___Diabetes, non-insulin dependent
___Hypothyroidism (low thyroid)
___Anemia
___Blood transfusions in past
___Blood clot---
----Right/ Left leg/ thigh in ____ (year)
___Congestive heart failure (CHF)
___Coronary artery disease
___High cholesterol/triglycerides (hyperlipidemia)
___Hypertension
___Heart murmur
___Heart attacks
___Mitral valve prolapsed (MVP)
___Stroke
___Pacemaker
___Stent ___cardiac ___femoral ___year
___Coronary arteries bypass surgery
___ (# vessels) ___year
___Artificial heart valve
___Pig valve ____St. Jude valve
___Asthma
___COPD
___Sleep apnea……CPAP? ___Yes ___No
___Pulmonary embolism… ____Year

____Systemic lupus erythematosus
____Psoriasis
____Fibromyalgia
____Polymyalgia rheumatic
____Fracture(s) of_____________
____Stomach ulcers
____GI bleed
____GERD (reflux disease)
____Gallbladder disease
___Liver disease besides hepatitis
____Kidney stones
____Renal failure
____Urinary incontinence
____Hepatitis, Type A B C D
____TB (tuberculosis) exposure
____Lyme disease
____HIV/ AIDS
____Parkinson's disease
____Peripheral neuropathy
____Seizures
____Cerebral palsy
____Depression
____Anxiety
____Alzheimer's dementia
____ADHD

___Pneumonia ___Mental retardation
___Other conditions not listed above________________________________
____

SURGERIES (specify Right or Left if applicable) Year MD City/State
NONE_____

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

Have you or a family member had a serious problems from anesthesia besides nausea & vomiting? ___No ___Yes (explain) __________________

MEDICATION & FOOD ALLERGIES (Include tape & latex allergies):
NONE ____

1. __________________
2. __________________
3. __________________
4. __________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

MEDICATIONS Dose How often Reason for Medication
NONE _____

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Females (under age 55): Are you pregnant? ____Yes ____No ___Uncertain
Check which symptoms are **NEW** within the last 3 months:

___Recent fever	____Shortness of breath	___Blood in spit
___Recent illness	____Chest pain	___Blood in vomit
___New onset fatigue	____Dizziness	___Blood in urine
___Other joint swelling	____Urinary pain/burning	___Depression
___Unexplained cough	____Incontinence (urinary)	___Anxiety
___Rash	____Constipation	___Insomnia
___Loss of appetite	____Memory problems	___Diarrhea
___Unexplained weight loss	____Abdominal pain	___Night sweats
___Unexplained weight gain	____Blood in stools	___Other

If 60 years or older: Have you had a DEXA scan for osteoporosis? __Yes __

Dental status: ___I have my own teeth ____Partial plate's ___Full dentures
I have current problems with my teeth or gums: ____Yes ____No
Date of last dental exam__________

IMMEDIATE FAMILY HISTORY (Please circle)

Father	___age if living	____age deceased
Mother	___age if living	____age deceased
Sister	___age if living	____age deceased
Brother	___age if living	____age deceased

ANY MAJOR PROBLEMS

___Heart disease	Father	Mother	Sister	Brother
___Stroke	Father	Mother	Sister	Brother
___Hypertension	Father	Mother	Sister	Brother
___Breast cancer	Father	Mother	Sister	Brother
___Prostate cancer	Father	Mother	Sister	Brother
___Lung disease	Father	Mother	Sister	Brother
___Diabetes	Father	Mother	Sister	Brother
___Kidney disease	Father	Mother	Sister	Brother
___Gout	Father	Mother	Sister	Brother
___Depression	Father	Mother	Sister	Brother
___Rheumatoid Arthritis	Father	Mother	Sister	Brother

Is there anything else we should know?
Signature of person filing out the form: _____________________________