ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

RHEUMATOLOGY MEDICAL HISTORY

Name : _____

DOB : ____ /____ /____ Date : ____ /____ /____

Referring doctor : _____ Local pharmacy : _____

Address : _____ Address : _____

Phone : _____ Phone : _____

PERSONAL HEALTH HISTORY

Briefly state your reason for seeing the doctor today. Please describe your current symptoms, when it started, and what you have done for it:

REVIEW OF SYSTEMS

Please use a check mark (V) to indicate whether you have had any of the conditions listed below over the LAST MONTH :

Constitutional	**Respiratory**	☐ Numbness or tingling of arms/legs
☐ Fever	☐ Shortness of breath	☐ Muscle Weakness
☐ Weight gain (>10 lbs)	☐ Wheezing	☐ Paralysis of arms/legs
☐ Weight loss (>10 lbs)	☐ Cough	☐ Muscle pain, aches, or cramps
☐ Feeling sickly	**Gastrointestinal**	☐ Swelling of hands
☐ Unusual Fatigue	☐ Loss of appetite	☐ Swelling of ankles
Head / Eye / Ear / Nose / Throat	☐ Heartburn or stomach gas	☐ Swelling in other joints
☐ Headaches	☐ Stomach pain or cramps	☐ Joint pain
☐ Dry eyes	☐ Nausea	☐ Back pain
☐ Other eye problems	☐ Vomiting	☐ Neck pain
☐ Fainting spells	☐ Constipation	**Skin**
☐ Problems with hearing	☐ Diarrhea	☐ Skin rash/hives
☐ Ringing in the ears	☐ Dark or bloody stools	☐ Loss of hair
☐ Stuffy nose	**Genitourinary**	☐ Other Skin problems
☐ Sores in the mouth	☐ Problems with urination	**Psychiatric**
☐ Swollen glands	☐ Gynecological (female) problems	☐ Depression – feeling blue
☐ Dry mouth	☐ Burning in sex organs	☐ Anxiety – feeling nervous
☐ Lump in your throat	☐ Sexual problems	☐ Problems with thinking
☐ Problems with smell or taste	**Endocrine**	☐ Problems with sleeping
☐ Trouble swallowing	☐ Unusual bruising or bleeding	☐ Problems with memory
Cardiovascular	**Neurological**	☐ Problems with social activities
☐ Pain in chest	☐ Dizziness	☐ Smoking cigarettes
☐ Heart pounding (palpitations)	☐ Losing your balance	☐ Use of drugs not sold in stores
		☐ More than 2 alcoholic drinks/day

Name: _____

Please list all major illnesses or hospitalizations (other than for operations):		
Year	**Reason**	**Hospital**

Please list all operations that you have ever had :		
Year	**Reason**	**Hospital**

Please use a check mark (V) to indicate whether you have had any of the conditions listed below :

Head / Eye / Ear / Nose / Throat	**Gastrointestinal**	**Musculoskeletal**
☐ Dry eyes	☐ Stomach ulcer	☐ Back or spine problems
☐ Cataracts	☐ Other gastrointestinal problem	☐ Osteoarthritis
☐ Dry Mouth	**Genitourinary**	☐ Rheumatoid arthritis
Cardiovascular	☐ Kidney problem	☐ Lupus
☐ High blood pressure	☐ Gynecological (female) problem	☐ Fibromyalgia
☐ Heart attack	☐ Prostrate (male) problem	☐ Broken bones after age 50
☐ Palpitations	**Endocrine**	☐ Osteoporosis
☐ Other heart disease	☐ Diabetes	**Skin**
Respiratory	☐ Thyroid disorder	☐ Psoriasis
☐ Asthma	**Hematologic**	☐ Other skin disease
☐ Severe allergies	☐ Problems with blood clotting	**Psychiatric**
☐ Emphysema	☐ Cancer	☐ Depression
☐ Bronchitis	**Neurologic**	☐ Alcoholism
☐ History of tuberculosis	☐ Stroke	☐ Mental illness
☐ Other respiratory disease	☐ Parkinson's disease	☐ Other:

MEDICATION HISTORY

LIST YOUR PRESCRIBED DRUGS

Name of drug	**Strength**	**Frequency Taken**

OVER THE COUNTER MEDICATIONS

Name of drug	**Strength**	**Frequency Taken**

ALLERGIES TO MEDICATIONS

Name the drug	**Reaction you had**

Name: _____

FAMILY HEALTH HISTORY					
	AGE	**SIGNIFICANT HEALTH PROBLEMS**		**AGE**	**SIGNIFICANT HEALTH PROBLEMS**
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** ***Maternal***		
	☐ M ☐ F		**Grandfather** ***Maternal***		
	☐ M ☐ F		**Grandmother** ***Paternal***		
	☐ M ☐ F		**Grandfather** ***Paternal***		

SOCIAL HISTORY						
HABITS						
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years		☐ Or years quit			
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Occupation	What is your current occupation?					
	If retired, what was your past occupation?					
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation less than 4x/week for 30 minutes)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day					
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Have you ever had a fracture (broken bone)?				☐ Yes	☐ No
Females Only	Have you gone through menopause?				☐ Yes	☐ No
	If YES, at what age?					
Bone Density	Have you had a bone density test done?				☐ Yes	☐ No
	If YES, when and where was this done?					

Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers</u>. Please answer exactly as you think or feel.

Name: _____

1.) Please place a check mark (√) in the appropriate spot for the ONE best answer for your abilities at this time:

	OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty (0)	With **SOME** Difficulty (1)	With **MUCH** Difficulty (2)	**UNABLE** To Do (3)
a.	Dress yourself, including tying shoelaces and doing buttons?				
b.	Get in and out of bed?				
c.	Lift a full cup or glass to your mouth?				
d.	Walk outdoors on flat ground?				
e.	Wash and dry your entire body?				
f.	Bend down to pick up clothing from the floor?				
g.	Turn regular faucets on and off?				
h.	Get in and out of a car, bus, train or airplane?				
i.	Walk two miles or three kilometers, if you wish?				
j.	Participate in recreational activities and sports as you would like?				

2.) Please indicate how severe your pain has been because of your condition OVER THE PAST WEEK?

NO PAIN	O 0	O 0.5	O 1.0	O 1.5	O 2.0	O 2.5	O 3.0	O 3.5	O 4.0	O 4.5	O 5.0	O 5.5	O 6.0	O 6.5	O 7.0	O 7.5	O 8.0	O 8.5	O 9.0	O 9.5	O 10	SEVERE PAIN

When did the pain begin?			
What makes you feel better?			
Worse?			
Do you have pain at rest? ☐ Yes ☐ No		Do you have pain with activity? ☐ Yes ☐ No	

3.) Please place a check mark (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

		None (0)	Mild (1)	Moderate (2)	Severe (3)			None (0)	Mild (1)	Moderate (2)	Severe (3)
a.	Left Fingers					i.	Right Fingers				
b.	Left Wrist					j.	Right Wrist				
c.	Left Elbow					k.	Right Elbow				
d.	Left Shoulder					l.	Right Shoulder				
e.	Left Hip					m.	Right Hip				
f.	Left Knee					n.	Right Knee				
g.	Left Ankle					o.	Right Ankle				
h.	Left Toes					p.	Right Toes				
q.	Neck					r.	Back				

4.) 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	O 0	O 0.5	O 1.0	O 1.5	O 2.0	O 2.5	O 3.0	O 3.5	O 4.0	O 4.5	O 5.0	O 5.5	O 6.0	O 6.5	O 7.0	O 7.5	O 8.0	O 8.5	O 9.0	O 9.5	O 10	VERY POORLY

When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐Yes ☐No
If "Yes", please indicate the number of minutes _____ or hours _____ until you are as limber as you will be for the day

How you feel TODAY compared to ONE WEEK AGO? Please check only one.
☐ Much better ☐ Better ☐ The Same ☐ Worse ☐ Much Worse

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

NO PROBLEM	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	MAJOR PROBLEM

ORTHOPAEDICS AND RHEUMATOLOGY OF THE NORTH SHORE

RHEUMATOLOGY HEALTH ASSESSMENT QUESTIONNAIRE

Name : _____

DOB : ____ /____ /____ Date : ____ /____ /____

Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel.

1.) Please place a check mark (√) in the appropriate spot for the ONE best answer for your abilities at this time:

	OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty (0)	With **SOME** Difficulty (1)	With **MUCH** Difficulty (2)	**UNABLE** To Do (3)
a.	Dress yourself, including tying shoelaces and doing buttons?				
b.	Get in and out of bed?				
c.	Lift a full cup or glass to your mouth?				
d.	Walk outdoors on flat ground?				
e.	Wash and dry your entire body?				
f.	Bend down to pick up clothing from the floor?				
g.	Turn regular faucets on and off?				
h.	Get in and out of a car, bus, train or airplane?				
i.	Walk two miles or three kilometers, if you wish?				
j.	Participate in recreational activities and sports as you would like?				

2.) Please indicate how severe your pain has been because of your condition OVER THE PAST WEEK?

NO PAIN	0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10	SEVERE PAIN
	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	

When did the pain begin?	
What makes you feel better? Worse?	
Do you have pain at rest? ☐ Yes ☐ No	Do you have pain with activity? ☐ Yes ☐ No

3.) Please place a check mark (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

		None (0)	Mild (1)	Moderate (2)	Severe (3)			None (0)	Mild (1)	Moderate (2)	Severe (3)
a.	Left Fingers					i.	Right Fingers				
b.	Left Wrist					j.	Right Wrist				
c.	Left Elbow					k.	Right Elbow				
d.	Left Shoulder					l.	Right Shoulder				
e.	Left Hip					m.	Right Hip				
f.	Left Knee					n.	Right Knee				
g.	Left Ankle					o.	Right Ankle				
h.	Left Toes					p.	Right Toes				
q.	Neck					r.	Back				

Name: _____

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

VERY	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	VERY
WELL	0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10	POORLY

5.) Please check mark (√) if you have experienced any of the following over the last month:

☐ Fever	☐ Lump in your throat	☐ Dark or bloody stools	☐ Joint pain
☐ Weight gain (> 10 lbs)	☐ Problems with smell or taste	☐ Problems with urination	☐ Back pain
☐ Weight loss (> 10 lbs)	☐ Trouble swallowing	☐ Gynecological (female) problems	☐ Neck pain
☐ Feeling sickly	☐ Pain in chest	☐ Burning in sex organs	☐ Skin rash/hives
☐ Unusual fatigue	☐ Heart pounding (palpitations)	☐ Sexual problems	☐ Loss of hair
☐ Headaches	☐ Shortness of breath	☐ Unusual bruising or bleeding	☐ Other skin problems
☐ Dry eyes	☐ Wheezing	☐ Dizziness	☐ Depression – feeling blue
☐ Other eye problems	☐ Cough	☐ Losing your balance	☐ Anxiety – feeling nervous
☐ Fainting spells	☐ Loss of appetite	☐ Numbness or tingling of arms/legs	☐ Problems with thinking
☐ Problems with hearing	☐ Heartburn or stomach gas	☐ Muscle weakness	☐ Problems with sleeping
☐ Ringing in the ears	☐ Stomach pain or cramps	☐ Paralysis of arms/legs	☐ Problems with memory
☐ Stuffy nose	☐ Nausea	☐ Muscle pain, aches or cramps	☐ Problems with social activity
☐ Sores in the mouth	☐ Vomiting	☐ Swelling of hands	☐ Smoking cigarettes
☐ Swollen glands	☐ Constipation	☐ Swelling of ankles	☐ Use of drugs not sold in stores
☐ Dry mouth	☐ Diarrhea	☐ Swelling in other joints	☐ More than 2 alcoholic drinks/day

Please check (√) here if you had none of the above over the last month _____.

6.) When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "No", please go to #7. If "Yes", please indicate the number of minutes ____ or hours ____ until you are as limber as you will be for the day.

7.) How do you feel TODAY compared to ONE WEEK AGO? Please check (√) only one.
☐ (1) Much Better ☐ (2) Better ☐ (3) The Same ☐(4) Worse ☐ (5) Much Worse

8.) How often do you exercise aerobically(sweating, increased heart rate, shortness of breath) **for at least 30 minutes? Please check (√) only one.**
☐ 3 or more times/week (3) ☐ 1-2 times per month (1)
☐ 1-2 times per week (2) ☐ Do not exercise regularly (0) ☐ Cannot exercise due to disability/handicap (9)

9.) How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

NO	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	MAJOR
PROBLEM	0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10	PROBLEM

10.) Over the last 6 months have you had: Please check (√).

☐ No ☐ Yes	An operation or new illness	☐ No	☐ Yes	Change(s) if arthritis or other medications
☐ No ☐ Yes	Medical emergency or hospital stay	☐ No	☐ Yes	Change(s) of address
☐ No ☐ Yes	A fall, broken bone or other accident/trauma	☐ No	☐ Yes	Change(s) of marital status
☐ No ☐ Yes	An important new symptom or medical problem	☐ No	☐ Yes	Change of work duties, quit work, retired
☐ No ☐ Yes	Side effect(s) of any medication or drug	☐ No	☐ Yes	Change of medical insurance, Medicare, etc.
☐ No ☐ Yes	Smoke cigarettes regularly	☐ No	☐ Yes	Change of primary care or other doctor

Please explain a "YES" answer or indicate any other health matter that affects you: _____

_____