Date ____/____/____

Rheumatology Associates of North Alabama, P.C.

Name ________________________________ (LAST) (FIRST) (MIDDLE)

Birthdate ____/____/____ (MONTH) (DAY) (YEAR)

Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ Sep

Sex: ☐ Female ☐ Male

The name of the physician providing your general medical care? ________________

Describe briefly your present symptoms ________________

____

PAST PERSONAL HISTORY:

Cancer	☐ No	☐ Yes	Heart Problems	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Thyroid Trouble	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes	Cataracts	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes	Depression	☐ No	☐ Yes	Stomach Ulcers	☐ No	☐ Yes	Rheumatic Fever	☐ No	☐ Yes
Bad Headaches	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes	Colitis	☐ No	☐ Yes	Renal Insufficiency	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Psoriasis	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Recent Tick Bite	☐ No	☐ Yes

Other Significant Illness (Please list) ________________

PREVIOUS OPERATIONS:

	Year	Surgeon	City
1)			
2)			
3)			

Do you have breast implants? ☐ No ☐ Yes

Have you had a bone density test (DEXA)? ☐ No ☐ Yes

Any other serious injuries? ☐ No ☐ Yes

Any previous fractures? ☐ No ☐ Yes

Describe ________________

Because of health problems, what are the most difficult things for you to do? ________________

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Medical Problems	Age At Death	Cause
Father				
Mother				
Siblings				
Children				
Children				

Have any of your family members had Arthritis or Rheumatism? ☐ No ☐ Yes

Cancer? ☐ No ☐ Yes

Lupus or Connective Tissue Disease? ☐ No ☐ Yes

Osteoporosis? ☐ No ☐ Yes

Circle the arthritis drugs you have taken in the past:

1. Actemra
2. Allopurinol (zyloprim /lopurin)
3. Arava (Leflunomide)
4. Arthrotec/Voltaren (diclofenac)
5. Azulifidine (sulfasalazine)
6. Benemid (probenecid)
7. Benlysta (belimumab)
8. Bextra (valdecoxib)
9. Celebrex (celecoxib)
10. Cellcept (mycophenolate mofetil)
11. Cimzia (certolizumab pegol)
12. Cymbalta (duloxetine)
13. Colchicine
14. Cytoxan (cyclophosphamide)
15. Darvon/Darvocet
16. Dolobid (diflunisal)
17. Elavil (amitriptyline)
18. Enbrel (etanercept)
19. Feldene (piroxicam)
20 Flexeril (cyclobenzaprine)
21. Humira (adalimumab)
22. Imuran (azathioprine)
23. Indocin (indomethacin)
24. Kineret (anakinra)
25. Krystexxa (pegloticase)
26. Lodine (etodolac)
27. Lyrica (pregabalin)
28. Methotrexate (rheumatrex)
29. Mobic (meloxicam)
30. Motrin / Advil /(ibuprofen)
31. Naprosyn / Naprelan (naproxen)
32. Orencia (abatacept)
33. Oruvail / Orudis (ketoprofen)
34. Neurontin
35. Pamelor (nortriptyline)
36. Plaquenil (hydroxychloroquine)
37. Prednisone (cortisone)
38. Prolia
39. Reclast
40. Relafen (nabumetone)
41. Remicade (Infliximab)
42. Sandimmune (cyclosporine)
43. Savella (milnacipran)
44. Simponi (golimumab)
45. Sinequan (doxepin)
46. Skelaxin (metaxalone)
47. Tolectin (tolmetin)
48. Toradol (ketorolac)
49. Ultram (tramadol HCL/Ultracet)
51. Zanaflex (tizanidine)

Other ________________

Other ________________

CURRENT MEDICATIONS

1. ________
2. ________
3. ________
4. ________
5. ________
6. ________
7. ________
8. ________
9. ________
10. ________
11. ________
12. ________
13. ________
14. ________

Please Continue on Reverse

Name ____________________

SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

GENERAL:

_______ Recent weight gain/Amount
_______ Recent loss of weight/Amount
_______ Fatigue
_______ Weakness
_______ Fever

NERVOUS SYSTEM:

_______ Headaches
_______ Dizziness
_______ Fainting
_______ Muscle spasm
_______ Loss of consciousness
_______ Sensitivity or pain of hands and/or feet
_______ Memory loss

EARS:

_______ Ringing in ears
_______ Loss of hearing

EYES:

_______ Pain
_______ Redness
_______ Loss of vision
_______ Double or blurred vision
_______ Feels like something in eye

NOSE:

_______ Nosebleeds
_______ Loss of smell
_______ Dryness

MOUTH:

_______ Sore tongue
_______ Bleeding gums
_______ Sores in mouth
_______ Loss of taste
_______ Dryness

THROAT:

_______ Frequent sore throats
_______ Hoarseness
_______ Difficulty in swallowing

NECK:

_______ Swollen glands
_______ Tender glands

HEART AND LUNGS:

_______ Pain in chest
_______ Irregular heart beat
_______ Sudden changes in heart beat
_______ Shortness of breath
_______ Difficulty in breathing at night
_______ Swollen legs or feet
_______ High blood pressure
_______ Heart murmurs
_______ Cough
_______ Coughing of blood
_______ Wheezing
_______ Night sweats

STOMACH AND INTESTINES:

_______ Nausea
_______ Vomiting of blood or coffee ground material
_______ Stomach pain relieved by food or milk
_______ Yellow jaundice
_______ Increasing constipation
_______ Persistent diarrhea
_______ Blood in stools
_______ Black stools
_______ Heartburn

KIDNEY / URINE / BLADDER:

_______ Difficult urination
_______ Pain or burning on urination
_______ Blood in urine
_______ Cloudy, "smoky" urine
_______ Pus in urine
_______ Discharge from penis/vagina
_______ Frequent urination
_______ Getting up at night to pass urine
_______ Vaginal dryness
_______ Rash/ulcers
_______ Sexual difficulties
_______ Prostate trouble

BLOOD:

_______ Anemia
_______ Bleeding tendency

SKIN:

_______ Easy bruising
_______ Redness
_______ Rash
_______ Hives
_______ Sun sensitive (sun allergy)
_______ Tightness
_______ Nodules / bumps
_______ Hair loss
_______ Color changes of hands or feet in the cold
____

MUSCLES / JOINTS / BONES:

_______ Morning stiffness
_______ Lasting how long
_______ Minutes
_______ Hours
_______ Joint pain
_______ Muscle weakness
_______ Muscle tenderness
_______ Joint swelling

List joints affected in the last 6 months

____

____

____

____

HABITS:

Do you smoke? ☐ Yes ☐ No ☐ Past
Cigarettes per day? ____________
How many years? ____________

Do you drink alcohol? ☐ Yes ☐ No
Daily alcohol intake ____________

How many pillows do you sleep on each night? ____________

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Date of last eye examination ____________________

Date of last chest X-Ray ____________________

Date of last Tuberculin Skin Test ____________________

MENSTRUAL:

Age when periods began _______ Periods Regular: ☐ Yes ☐ No Date of last period ____________

Date of last Pap smear: ____________ Bleeding after menopause: ____________

Have you ever taken hormones? ☐ Yes ☐ No Length of time taking hormones: ____________

Are you taking hormones now? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No When was your last mammogram? ____________

Were your ovaries removed? ☐ Yes ☐ No