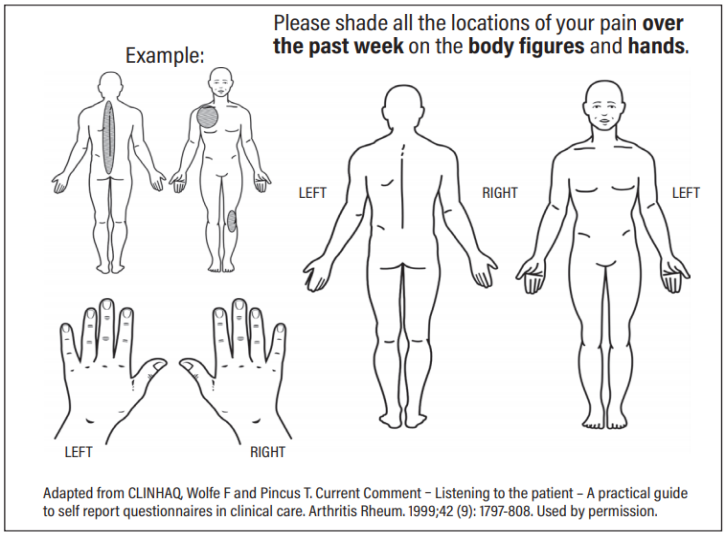
Central Florida Rheumatology Consultants, LLC

Lance Feller, MD, FACR
Board Certified in Rheumatology

Patient History Form

Date of appointment: ____/____/_____ Birthplace: _____
Name: _____ Birthdate:_____/_____/_____
Address: _____ Age_____ Sex: ☐ F ☐ M
_____ Telephone: Home: (____) _____
CITY STATE ZIP Work: (____) _____
Occupation_____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Referred here by: *(check one)*
Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional ☐
Name of person making referral: _____
Primary Care Provider: _____
Describe briefly your present symptoms:
_____
_____
_____
_____
_____
Date symptoms began (approximate):_____
Diagnosis (if known):_____
Previous treatment for this problem (include physical therapy, surgery and injections; medication to be listed later):
_____
_____
_____
_____



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.

HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

	Yourself	**Relative** Name/Relationship		**Yourself**	**Relative** Name/Relationship
Arthritis(unknown type)			Lupus or "SLE"		
Osteoarthritis			Rheumatoid Arthritis		
Gout			Ankylosing Spondylitis		
Childhood Arthritis			Osteoporosis		

Other arthritis conditions: _____
_____
_____

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SYSTEMS REVIEW

As you review the following list, please **check** any problems, which have significantly affected you:

Constitutional
- ☐ Recent weight gain amount_____
- ☐ Recent weight loss amount_____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Dryness

Ears-Nose-Mouth-Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Dryness of mouth
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat

Respiratory
- ☐ Shortness of breath
- ☐ Cough

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Blood in urine

For Women Only:
- ☐ Number of pregnancies?_____
- ☐ Number of miscarriages? _____

Musculoskeletal
- ☐ Morning stiffness
- ☐ Lasting how long? ____Minutes____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
- ☐ List of joints affected in the last 6 mos.

_____
_____
_____

Skin
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair Loss
- ☐ Color changes of hands/feet

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Sensitivity in hands/feet

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Anemia
- ☐ Bleeding tendency

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SOCIAL HISTORY

Do you smoke? YES ☐ NO ☐ Past- How long ago?____
Do you drink alcohol? Yes☐ No☐ Number per week___
Do you use drugs for reasons that are not medical?
☐ YES ☐ NO
If yes, please list:_____
_____

Do you exercise regularly? ☐ YES ☐ NO
Type_____
Amount per week _____
How many hours of sleep do you get at night? _____
Do you get enough sleep at night? ☐ YES☐ NO
Do you wake up feeling rested? ☐ YES☐ NO

PAST MEDICAL HISTORY

Please check if you have or ever had:

☐ Cancer
☐ Leukemia
☐ Cataracts
☐ HIV/AIDS
☐ Bad headaches
☐ Kidney disease
☐ Anemia
☐ Emphysema
☐ COPD
☐ Heart problems
☐ Tuberculosis
☐ Stomach ulcers
☐ Asthma
☐ Epilepsy
☐ Stroke
☐ Rheumatic fever
☐ Colitis
☐ Psoriasis
☐ High blood pressure
☐ Tuberculosis
☐ Diabetes

Other significant illness: _____
_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, etc)
_____
_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				

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Family History *Continued*

Number of siblings _____ Number living_____ Number deceased _____

Number of children _____ Number living_____ Number deceased _____

Health of children _____

_____

Do you know any blood relative that has or had: (check and give relationship)

☐ Cancer_____ ☐ Heart disease _____ ☐ Psoriasis _____

☐ Leukemia_____ ☐ High blood pressure_____ ☐ Blood clots_____

☐ Stroke _____ ☐ Asthma_____ ☐ Lupus_____

☐ Colitis _____ ☐ Ankylosing spondylitis_____

☐ Diabetes_____ ☐ Rheumatoid arthritis_____

MEDICATIONS

Drug Allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

CURRENT MEDICATIONS

(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9.		
10.		

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PAST MEDICATIONS

Please review this list of Rheumatology medications. As accurately as possible, try to remember which medications you have taken, how long you were the medication, the results of taking the medication and list any reaction you may have had. *Record your comment in the spaces provided.*

Drug names/ Dose	**Length of time**	**Please check: Helped? A lot**	**Some**	**Not At All**	**Reactions**
Non- Steroidal Anti-Inflammatory Drugs					
Circle any you have taken in the past: Diclofenac Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Flurbipofen Aspirin(including coated aspirin) Celebrex Sulindac Oxaprozin Meloxicam Nabumetone Diclofenac +misoprostil Salsalate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Cholone magenesium trisalcylate					
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		☐	☐	☐	
Golimumab		☐	☐	☐	
Hydroxychlorquine		☐	☐	☐	
Methotrexate		☐	☐	☐	
Azazthioprine		☐	☐	☐	
Sulfasalazine		☐	☐	☐	
Cyclophosphamide		☐	☐	☐	
Enbrel		☐	☐	☐	
Infliximab		☐	☐	☐	
Acterma		☐	☐	☐	
Taltz		☐	☐	☐	
Cosentyx		☐	☐	☐	
Otezla		☐	☐	☐	
Mycophenolete		☐	☐	☐	
Leflunomide		☐	☐	☐	
Humira		☐	☐	☐	
Xeljanz		☐	☐	☐	
Rituximab		☐	☐	☐	
Orencia		☐	☐	☐	
Rinvoq		☐	☐	☐	
Olumiant		☐	☐	☐	
Kevzara		☐	☐	☐	
Other:		☐	☐	☐	

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PAST MEDICATIONS *Continued*

Drug names/ Dose	Length of time	Reactions
Osteoporosis Medications		
Estrogen		
Alendronate		
Raloxifene		
Calcitonin injection or nasal		
Risedronate		
Prolia		
Forteo		
Evenity		
Tymlos		
Gout Medications		
Probenecid		
Colchicine		
Allopurnol		
Uloric		
Other:		

Please list supplements: _____

_____

_____

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

if yes, list:_____

_____

_____

_____

_____

_____

_____