Central Florida Rheumatology Consultants, LLC

Lance Feller, MD, FACR
Board Certified in Rheumatology

Patient History Form

Date of appointment: ____/____/_____ Time of appointment: _________ Birthplace: _____________
Name: ____ Birthdate:______/_______/_______
Address: ____ Age__________ Sex: ☐ F ☐ M
____ Telephone: Home: (____) ______
CITY STATE ZIP Work: (____) ______

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age____ ☐ Deceased/Age____ Major Illnesses: ______________

Occupation_______________________________________

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:

____

____

____

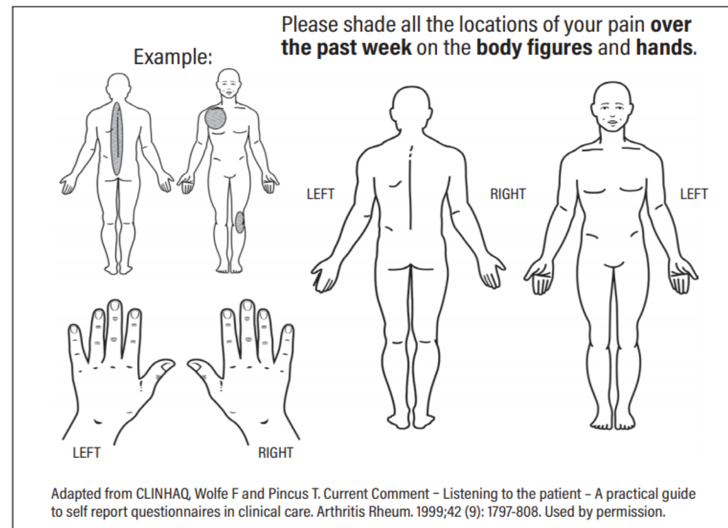
Date symptoms began (approximate):______________

Diagnosis: _______________________________________

Previous treatment for this problem (include physical therapy, surgery and injections; medication to be listed later):

____

____



RHEUMATOLOGIC (ARTHRITIS) 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:
Date of last bone densitometry _____/______ /______

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

Eyes
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

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

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough

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

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, “smoky” urine
- ☐ Pus 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
- ☐ Loss of consciousness
- ☐ Sensitivity in hands/feet

Endocrine
- ☐ Excessive thirst

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

Allergic/ Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

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SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? ____________

Do you smoke? ☐ Yes ☐ No ☐ Past- How long ago? ___

Do you drink alcohol? ☐ Yes ☐ No Number per week ___

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

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 a night? _________

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

Do you wake up feeling rested? ☐ Yes ☐ No

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

____

____

PAST MEDICAL HISTORY

Please check if you have or ever had:

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

Other significant illness: ______________

____

PREVIOUS SURGERIES

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

Any previous fractures? ☐ No ☐ Yes Describe: ______________________________________

Any other serious injuries? ☐ 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___________ ☐ Tuberculosis__________

☐ Diabetes________ ☐ Rheumatoid arthritis____________ ☐ Goiter________________

MEDICATIONS

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

____

Type of reaction: ____

PRESENT 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	Please check: Helped? A lot	Some	Not At All
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	Please check: Helped? A lot	Some	Not At All	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:____

____

____

____

____

____

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☐