RUSH MEMORIAL HOSPITAL

Primary Care Provider: _____
Diagnosis (if applicable): _____
Which provider is the patient wanting to see? ☐ Dr. Moazzem
☐ Dr. Key
☐ First Available

Patient History Form

Birthplace: _____

Name: _____ Birthdate: ____/____/____ Age: _____
LAST FIRST M.I. MAIDEN

Address: _____ Sex: ❒ Female ❒ Male
STREET APARTMENT #

_____ Telephone: Home (_____)_____ Work (_____)_____
CITY STATE ZIP

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

Spouse / Significant Other: ❒ Alive / Age ___ ❒ Deceased / Age ___ ❒ Major Illness _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked on average per week _____

Referred here by: (check one) ❒ Self ❒ Family ❒ Friend ❒ Doctor ❒ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❒ Yes ❒ No If yes, Name: _____

Describe briefly your present symptoms: _____
_____
_____
_____

Date symptoms began (approximate): _____
_____

Diagnosis: _____

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

Please list the names of other practitioners you have seen for this problem:
_____
_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself	Condition	Relative Name / Relationship	Yourself	Condition	Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name: _____ Date: _____ Physician's Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.
Date of last mammogram: ___/___/___ Date of last eye exam: ___/___/___ Date of last chest x-ray: ___/___/___
Date of last Tuberculosis Test ___/___/___ Date of last bone densitometry: ___/___/___

Constitutional

❒ Recent weight gain
Amount _____
❒ Recent weight loss
Amount _____
❒ Fatigue
❒ Weakness
❒ Fever

Eyes

❒ Pain
❒ Redness
❒ Loss of vision
❒ Double of blurred vision
❒ Dryness
❒ Feels like something in eye
❒ Itching eyes

Ears – Nose – Mouth – Throat

❒ Ringing in ears
❒ Loss of hearing
❒ Nosebleeds
❒ Loss of smell
❒ Dryness in nose
❒ Runny nose
❒ Sore tongue
❒ Bleeding gums
❒ Sores in mouth
❒ Loss of taste
❒ Dryness of mouth
❒ Frequent sore throats
❒ Hoarsness
❒ Difficulty in swallowing

Cardiovascular

❒ Pain in chest
❒ Irregular heart beat
❒ Sudden changes in heart beat
❒ High blood pressure
❒ Heart murmurs

Respiratory

❒ Shortness of breath
❒ Difficulty in breathing at night
❒ Swollen legs or feet
❒ Cough
❒ Coughing of blood
❒ Wheezing (asthma)

Gastrointestinal

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

Genitourinary

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

For Women Only:

Age when periods began: _____
Periods regular? ❒ Yes ❒ No
How many days apart?
Date of last period? _____/_____/_____
Date of last pap? _____/_____/_____
Bleeding after menopause? ❒ Yes ❒ No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal

❒ Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
❒ Joint pain
❒ Muscle weakness
❒ Muscle tenderness
❒ Joint swelling

List joints affected in the last 6 months:
_____
_____
_____
_____

Integumentary (skin and / or breast)

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

Neurological System

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

Psychiatric

❒ Excessive worries
❒ Anxiety
❒ Easily losing temper
❒ Depression
❒ Agitation
❒ Difficulty falling asleep
❒ Difficulty staying asleep

Endocrine

❒ Excessive thirst

Hematologic / Lymphatic

❒ Swollen glands
❒ Tender glands
❒ Anemia
❒ Bleeding tendency
❒ Transfusion / when _____

Allergic / Immunologic

❒ Frequent sneezing
❒ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician's Initials _____

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 at night? _____

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

Do you wake up feeling rested? ❒ Yes ❒ No

PAST MEDICAL HISTORY

Do you or have you ever had (check if "yes")

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

Other significant illness (please list): _____

_____

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

_____

_____

PREVIOUS OPERATIONS

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				

Number of siblings: _____ Number living: _____ Number deceased: _____

Number of children: _____ Number living: _____ Number deceased: _____ List ages of each: _____

Health of children: _____

_____

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

❒ Cancer _____ ❒ Heart disease _____ ❒ Rheumatic fever _____ ❒ Tuberculosis _____

❒ Leukemia _____ ❒ High blood pressure _____ ❒ Epilepsy _____ ❒ Diabetes _____

❒ Stroke _____ ❒ Bleeding tendency _____ ❒ Asthma _____ ❒ Goiter _____

❒ Colitis _____ ❒ Alcoholism _____ ❒ Psoriasis _____

Patient's Name: _____ Date: _____ Physician's Initials: _____

08/2009, 03/2012, 11/2013

MEDICATIONS

Drug allergies: ❒ No ❒ Yes To what? _____

_____

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.			❒	❒	❒

PAST MEDICATIONS – Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the space provided below.

Drug names / Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Pain Relievers					
Acetaminophen		❒	❒	❒	
Codeine (Vicodin, Tylenol 3)		❒	❒	❒	
Propoxyphene (Darvon ./ Darvocet)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❒	❒	❒	
Gold shots (Myochrysine or Solganol)		❒	❒	❒	
Hydroxychloroquine (Plaquenil)		❒	❒	❒	
Penicillamine (Cuprimine or Depen)		❒	❒	❒	
Methotrexate (Rheumatrex)		❒	❒	❒	
Azathioprine (Imuran)		❒	❒	❒	
Sulfasalazine (Azulfidine)		❒	❒	❒	
Quinacrine (Atabrine)		❒	❒	❒	
Cyclophosphamide (Cytoxan)		❒	❒	❒	
Cyclosporine A (Sandimmune or Neoral)		❒	❒	❒	
Etanercept (Enbrel)		❒	❒	❒	
Infliximab (Remicade)		❒	❒	❒	
Prosorba Column		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	

Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

Circle any you have taken in the past

Ansaid (flurbiprofen)	Arthrotec (diclofenac + misoprostil)	Aspirin (including coated aspirin)	Celebrex (celecoxib)	Clinoril (sulindac)
Daypro (oxaprozin)	Disalcid (salsalate)	Dolobid (diflunisal)	Feldene (piroxicam)	Indocin (indomethacin)
Lodine (etodolac)	Meclomen (meclofenamate)	Motrin/Rufen (ibuprofen)	Nalfon (fenoprofen)	Naprosyn (naproxen)
Oruvail (ketoprofen)	Tolectin (tolmetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac)

Patient's Name: _____ Date: _____ Physician's Initials: _____

PAST MEDICATIONS Continued

Drug names / Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen (Premarin, etc.)		❒	❒	❒	
Alendronate (Fosamax)		❒	❒	❒	
Etidronate (Didronel)		❒	❒	❒	
Raloxifene (Evista)		❒	❒	❒	
Fluoride		❒	❒	❒	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❒	❒	❒	
Risedronate (Actonel)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Gout Medications					
Probenecid		❒	❒	❒	
Colchicine		❒	❒	❒	
Allopurinol (Zyloprim / Lopurin)		❒	❒	❒	
Other:		❒	❒	❒	
Other:		❒	❒	❒	
Others					
Tamoxifen (Nolvadex)		❒	❒	❒	
Tilidronate (Skelid)		❒	❒	❒	
Cortisone / Prednisone		❒	❒	❒	
Hyalgan / Synvisc injections		❒	❒	❒	
Herbel or Nutritional Supplements		❒	❒	❒	
Please list supplements:					

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

If yes, please list: _____

_____

_____

_____

Patient's Name: _____ Date: _____ Physician's Initials: _____

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❒ Yes ❒ No If yes, how many? _____

How many people in household? _____ Relationship and age of each: _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best described your situation; *Most of the time, I function…*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❒	❒	❒
Walking?	❒	❒	❒
Climbing stairs?	❒	❒	❒
Descending stairs?	❒	❒	❒
Sitting down?	❒	❒	❒
Getting up from chair?	❒	❒	❒
Touching your feet while seated?	❒	❒	❒
Reaching behind your back?	❒	❒	❒
Reaching behind your head?	❒	❒	❒
Dressing yourself?	❒	❒	❒
Going to sleep?	❒	❒	❒
Staying asleep due to pain?	❒	❒	❒
Obtaining restful sleep?	❒	❒	❒
Bathing?	❒	❒	❒
Eating?	❒	❒	❒
Working?	❒	❒	❒
Getting along with family members?	❒	❒	❒
In your sexual relationship?	❒	❒	❒
Engaging in leisure time activities?	❒	❒	❒
With morning stiffness?	❒	❒	❒
Do you use a cane, crutches, a walker or wheelchair? (circle one)	❒	❒	❒

What is the hardest thing for you to do? _____

Are you receiving disability?	❒ Yes	❒ No
Are you applying for disability?	❒ Yes	❒ No
Do you have a medically related lawsuit pending?	❒ Yes	❒ No

Patient's Name: _____ Date: _____ Physician's Initials: _____