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: (___) _____

Email Address:_____

Occupation (if retired, prior): _____

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:_____

Preferred Lab:_____

Diagnosis (if known):_____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate):_____

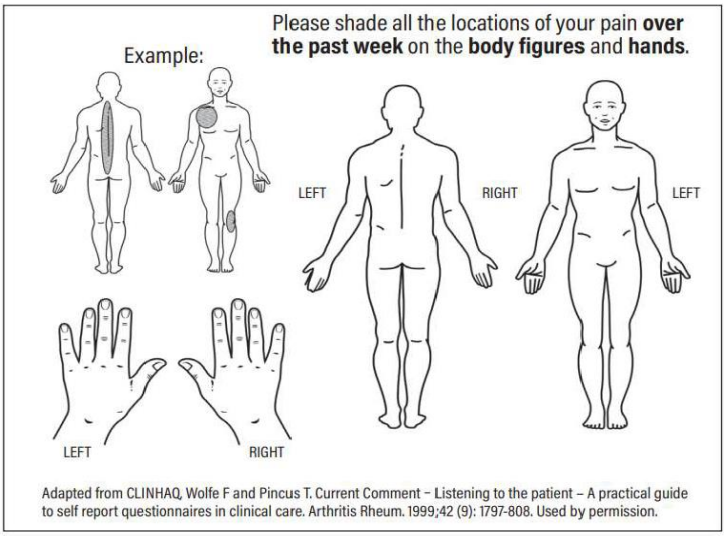
Previous treatment for this problem (include physical therapy, surgery and injections; medication to be listed later):

_____

_____

_____

_____



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.

FAMILY HISTORY

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

		Relationship			Relationship
Psoriasis	❑		Lupus or "SLE"	❑	
Osteoarthritis	❑		Rheumatoid Arthritis	❑	
Gout	❑		Ankylosing Spondylitis	❑	
Childhood Arthritis	❑		Osteoporosis	❑	

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SYSTEMS REVIEW

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

Constitutional		**Gastrointestinal**		**Skin**	
❑	Recent weight gain	❑	Nausea	❑	Easy bruising
❑	Recent weight loss	❑	Vomiting	❑	Redness
❑	Fatigue	❑	Persistent diarrhea	❑	Rash
❑	Weakness	❑	Heartburn	❑	Sun sensitivity
❑	Fever	**Genitourinary**		❑	Hair loss
❑	Night sweats	❑	Blood in urine	❑	Color change of hands/feet
Eyes		**Musculoskeletal**		**Neurological System**	
❑	Pain	❑	Morning stiffness	❑	Headaches
❑	Redness	How long? ___mins____hrs		❑	Dizziness
❑	Dryness	❑	Joint pain	❑	Muscle spasm
Ear-Nose-Throat		❑	Muscle weakness	**Hematologic/Lymphatic**	
❑	Loss of hearing	❑	Muscle tenderness	❑	Swollen glands
❑	Nosebleeds	❑	Joint swelling	❑	Anemia
❑	Sores in mouth	**For Women Only**		❑	Bleeding tendency
❑	Dryness of mouth	❑	Number of pregnancies? _____		
❑	Difficulty swallowing	❑	Number of miscarriages? _____		
Respiratory					
❑	Shortness of breath				
❑	Cough				

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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 _____

MEDICAL HISTORY

Please check if you have or ever had:

☐ Cancer; type:_____year:_____

Treatment(s):_____

☐ Cataracts ☐ Epilepsy
☐ Diabetes ☐ Stroke
☐ Psoriasis ☐ Rheumatic fever
☐ Kidney disease ☐ Ulcerative Colitis
☐ Anemia ☐ Crohn's Disease
☐ Emphysema ☐ High blood pressure
☐ COPD ☐ Tuberculosis

☐ Heart disease; desc:_____
☐ Tuberculosis ☐ Hepatitis
☐ Stomach Ulcers ☐ Asthma

Have you been to the hospital recently?
If yes, when? _____
Other significant illness:
_____

Have you received Human Papillomavirus, Hep A, or Hep B vaccine? ❑ Yes ❑ No
If yes, what/when? _____
Are you at risk for contracting HIV or Hepatitis through blood exposures or sexual activities? ❑ Yes ❑ No
Have you ever been tested for HIV? ❑ Yes ❑ No
Would you like to be tested for HIV? ❑ Yes ❑ No
Would you like to be tested for other STIs? ❑ Yes ❑ No

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Any previous fractures? ❑ Yes ❑ No
If yes, please describe (include time, treatment, etc.)
_____

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

_____

_____

FAMILY HISTORY

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

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.		
11.		
12.		
13.		
14.		
15.		

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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 on 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	Helped A lot	Helped Some	Did not help	Reactions
Non- Steroidal Anti-Inflammatory Drugs (NSAID)		☐	☐	☐	

Circle any you have taken in the past (circle):

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

Treatment for Autoimmune Diseases (skip if not applicable)

Drug Name	IV, Injection, Both, or Oral	Did the medication help? (yes/no)	Why stopped?	Reactions
Certolizumab (Cimzia)				
Golimumab (Simponi)				
Hydroxychlorquine (plaquenil)				
Methotrexate				
Azazthioprine (Imuron)				
Sulfasalazine				
Cyclophosphamide				
Enbrel (etanercept)				
Infliximab (remicade)				
Actemra (tocilizumab)				
Taltz				
Cosentyx				
Otezla				
Mycophenolete				
Leflunomide (araua)				
Humira (adalimumab)				
Xeljanz (tofacitinab)				
Rituximab (rixutan)				
Orencia (abatacept)				

Rinvoq				
Olumiant				
Kevzara				
Saphnelo				
Benlysta (belimumab)				
Tremfya (guselkumab)				
Other:				

Treatment for Osteoporosis (skip if not applicable)				
Drug Name	**IV, Injection, Both, or Oral**	**Did the medication help? (yes/no)**	**Why stopped? Or "ongoing"**	**Reactions**
Estrogen				
Alendronate (fosomax)				
Raloxifene				
Calcitonin				
Risedronate				
Prolia (denosumab)				
Forteo				
Evenity				
Tymios				
Treatment for Gout (skip if not applicable)				
Probenecid				
Colchicine				
Allopurnol				
Uloric				
Krustexxa				

Please list supplements:

_____

_____

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

if yes, list:_____

_____