DYNAMIC ARTHRITIS CARE CLINIC Patient History

Biographical Data

Name: _____Birthdate: ___/___/____
Last First Middle Initial

Age: _____ Sex: ☐F ☐M

Marital Status: ☐ Never married, ☐ Married, ☐ Divorced, ☐ Separated, ☐ Widowed Name of

Name of Spouse: _____

Employer: _____ Occupation: _____

Work Address: _____

Main reason for your visit:

☐ Joint pain ☐ Muscle pain ☐ Back pain ☐ Muscle Weakness
☐ Abnormal blood test, which one: _____ ☐ Bone health (osteoporosis)
☐ Headache ☐ Rash ☐ Eye inflammation (diagnosed by ophthalmologist)
☐ Other:_____

Rheumatological (Arthritis) History:
At any time have you or a blood relative had any of the following: (*check if yes*)

Yourself	Relative/ Relationship		Yourself	Relative/ Relationship	
☐	☐	Arthritis (any type)	☐	☐	Lupus
☐	☐	Rheumatoid arthritis	☐	☐	Ankylosing Spondylitis
☐	☐	Psoriatic arthritis	☐	☐	Osteoporosis
☐	☐	Osteoarthritis (“old age arthritis”)	☐	☐	Polymyositis/ Dermatomyositis
☐	☐	Childhood arthritis	☐	☐	Sjogren syndrome
☐	☐	Gout	☐	☐	Uveitis (eye inflammation)

Other types of arthritis conditions: _____

Social History:

Smoking history: ☐ Never smoker ☐ Former smoker, when did you quit? _____
☐ Current smoker, how many cigarettes per day? _____
Do you drink alcohol in a regular basis? ☐ No, ☐ Yes, how often? _____
Do you use recreational drugs? ☐ No, ☐ Yes, which one (s)? _____

General Past Medical History:

Do you have or have you ever had: (*check all that apply*)

- ☐ Thyroid disease (hypothyroidism)
- ☐ Diabetes mellitus (high blood sugar)
- ☐ High blood pressure
- ☐ Enphysema/ COPD
- ☐ High cholesterol
- ☐ Headaches/ Migraines
- ☐ Anemia
- ☐ Depression
- ☐ Heart failure
- ☐ Coronary Artery Disease (heart attack, angina)
- ☐ HIV/ AIDS
- ☐ Stomach ulcer
- ☐ Glaucoma
- ☐ Hepatitis ☐ B ☐ C
- ☐ Ulcerative colitis
- ☐ Anxiety
- ☐ Tuberculosis
- ☐ Cancer Where? _____
- ☐ Seizures/ epilepsy
- ☐ Psoriasis
- ☐ Stroke
- ☐ Nasal allergies
- ☐ Crohn Disease
- ☐ Chronic Kidney Disease

Other significant conditions: _____

_____

Previous surgeries:

Year	Type	Reason

Family History:

Do you know any blood relative that has or had?

- ☐ Cancer _____
- ☐ Tuberculosis _____
- ☐ High blood pressure _____
- ☐ Heart Disease _____
- ☐ Leukemia _____
- ☐ Stroke _____
- ☐ High blood sugar _____
- ☐ Bleeding tendency _____
- ☐ Psoriasis _____
- ☐ Colitis _____
- ☐ High Cholesterol _____
- ☐ Goiter _____

Other significant diseases in the family: _____

_____

Medications

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

Drug Name	Reaction

Current Medications:

Name of Drug	Dose, strength and frequency	Reason

Have you ever used? *(Circle all that apply)*

Non steroidal Anti inflammatories (NSAIDS)

Flurbiprofen	Diclofenac	Aspirin	Celecoxib	Sulindac
Oxaprozin	Salsalate	Diflunisal	Piroxicam	Indomethacin
Etodolac	Meclofenamate	Tolmetin	Fenoprofen	Naproxen
Ibuprofen				

Anti-arthritis medications (DMARDS)

Hydroxychloroquine	Methotrexate	Sulfasalazine	Leflunomide	Azathioprine
Cyclosporine	Cyclophosphamide			

Biologics

Enbrel	Humira	Simponi	Cimzia	Remicade
Actemra	Orencia	Rituxan	Benlysta	Cosentyx
Stelara				

Other anti-rheumatic drugs

Xeljanz	Otezla

Gout medications

Colchicine	Allopurinol	Uloric	Probenecid	Zurampic
Krystexxa				

Osteoporosis medications

Alendronate	Atelvia/ Actonel	Boniva	Evista	Estrogen hormones
Calcitonin	Reclast			

Steroids

prednisone	Methylprednisolone