# ARC-Rheumatology History and Intake Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Occupation / Workplace: _____

Emergency Contact (name): _____ Emergency Contact (number): _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

***Primary Care Provider:*** _____ ***Referring Physician:*** _____

## Preferred Pharmacy

**(Primary Local pharmacy - *default*)**

Name: _____

Phone Number: _____

City or Zip Code: _____

**(Secondary – Mail in pharmacy-*if applicable*)**

Name: _____

Phone Number: _____

City or Zip Code: _____

## Rheumatological History

**Have you had any of the following?**

- ☐ NONE
- ☐ Ankylosing Spondylitis: How long? _____
- ☐ DISH
- ☐ Fibromyalgia: How long?____
- ☐ Gout How long? _____
- ☐ Inflammatory Bowel Disease
- ☐ MCTD (Mixed connective tissue disease): How long? _____
- ☐ Osteoarthritis(Specify):_____
- ☐ Osteopenia
- ☐ Osteoporosis: How long?
- ☐ Pseudogout
- ☐ Psoriatic Arthritis: How long? _____
- ☐ Rheumatoid arthritis: How long? _____
- ☐ Sciatica
- ☐ Scleroderma: How long? ____
- ☐ Scoliosis
- ☐ Sjogren's : How long? _____
- ☐ Lupus (SLE): How long? _____
- ☐ Spinal arthritis/disc disease: **SPECIFY:** *Cervical* *Lumbar*
- ☐ Spinal Stenosis: **SPECIFY:** *Cervical* *Lumbar*
- ☐ Vertebral Body Compression Fracture: How long ago? _____
- ☐ Vitamin D Deficiency

OTHER(S):

- ☐ Cutaneous/discoid lupus How long: _____
- ☐ Skin Psoriasis How long: _____
- ☐ Other

_____

_____

_____

_____

**If you HAVE RHEUMATOID ARTHRITIS, how active has your arthritis been during the last seven days? (Draw vertical line)**

**0---------10---------20--------30---------40---------50---------60---------70---------80---------90---------100**

(0 = no activity) (100= highest activity possible)

# ARC-Rheumatology History and Intake Form

## Past Medical History

**Select any of the following medical conditions you currently have:**

- ☐ NONE
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes: How long? _____
- ☐ GERD
- ☐ Hepatitis: Specify B or C
- ☐ HIV / AIDS: How long? ____
- ☐ Hypercholesterolemia
- ☐ Glaucoma
- ☐ Hypertension
- ☐ Obesity
- ☐ Radiation Therapy
- ☐ Seizures/Epilepsy
- ☐ Stroke

**OTHER(S)**

- ☐ Cancer (Specify):_____

  How long? _____
- ☐ Chemotherapy
- ☐ Blood clots (Specify):_____
- ☐ Lung disease (Specify):_____
- ☐ Prior Tuberculosis/+ PPD

  How long: _____

  Treated: Yes No
- ☐ Peripheral neuropathy
- ☐ Other neurological disease

  Specify: _____
- ☐ Headaches (Specify):_____
- ☐ Congestive heart failure
- ☐ Heart Attack/MI
- ☐ Liver disease (Specify):_____
- ☐ Fatty liver
- ☐ Fractures: Specify: _____
- ☐ Chronic kidney disease

  How long?:_____
- ☐ Sleep apnea

  Using CPAP: YES NO
- ☐ Other

  _____
  _____
  _____
  _____

## Musculoskeletal Surgery

**Have you had any of the following?**

- ☐ NONE
- ☐ Carpal Tunnel Decompression

  **SPECIFY**: *Right Left Both*

  Year done: _____
- ☐ Distal Radius ORIF

  **SPECIFY**: *Right Left Both*

  Year done: _____
- ☐ Joint Replacement: *Hip*

  **SPECIFY:** *Right Left Both*

  Year done: _____
- ☐ Joint Replacement: *Knee*

  **SPECIFY:** *Right Left Both*

  Year done: _____
- ☐ Joint Replacement: *Shoulder*

  **SPECIFY:** *Right Left Both*

  Year done: _____
- ☐ Knee Arthroscopy

  **SPECIFY:** *Right Left Both*

  Year done: _____
- ☐ Kyphoplasty / Vertebroplasty

  Year done: _____
- ☐ Lumbar Spine Surgery: *Decompression*

  Year done: _____
- ☐ Lumbar Spine Surgery: *Decompression and Fusion*

  Year done: _____
- ☐ Lumbar Spine Surgery: *Disc Replacement*

  Year done: _____
- ☐ Rotator Cuff Repair

  **SPECIFY:** *Right Left Both*

  Year done: _____

**OTHER:**

- ☐ Trigger finger release

  Year done: _____
- ☐ Other

  _____
  _____
  _____

# ARC-Rheumatology History and Intake Form

## Past Surgical History

**Have you had any surgeries on the following organs?**

- ☐ NONE
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: *Lumpectomy*
- ☐ Breast: *Mastectomy*
- ☐ Colon (Colectomy): *Colon Cancer Resection*
- ☐ Colon (Colectomy): *Diverticulitis*
- ☐ Colon (Colectomy): *Inflammatory Bowel Disease*
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery (CABG)
- ☐ Heart: Valve Replacement
- ☐ Heart: PTCA/Cardiac catheterization
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney : Nephrectomy
- ☐ Kidney biopsy: How long? _____
- ☐ Liver: Hepatectomy
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy: Specify: _____
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer

OTHER:

- ☐ Liver biopsy: How long: _____
- ☐ Bone marrow biopsy: How long: _____

- ☐ Other

_____
_____
_____
_____

# ARC-Rheumatology History and Intake Form

## Medications

I. **Please list ALL your CURRENT RHEUMATOLOGIC or PAIN drugs, including over the counter pain killers:**

☐ *Currently not taking any RHEUMATOLOGICAL OR PAIN KILLERS medication(s) of any type*

| Medication | Dosage | Frequency | Date started | Helping? (yes or no) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

II. **Please list ALL OTHER NON RHEUMATOLOGICAL DRUGS you are taking, INCLUDING aspirin, vitamins, supplements, etc (DO NOT INCLUDE DOSE/FREQUENCY).**

☐ *Currently not taking any other medication(s) of any type*

| Medication | Medications | Medications |
|---|---|---|
| 1 | 6 | 11 |
| 2 | 7 | 12 |
| 3 | 8 | 13 |
| 4 | 9 | 14 |
| 5 | 10 | 15 |

## Allergies

**Please list ALL known allergies and describe your reaction(s) with severity provided below *(or check the box if it applies)***

☐ *No Known Allergies (NKA)*

| Allergy | Reaction(s) | Severity |
|---|---|---|
| 1.) _____ | _____ | _____ |
| 2.) _____ | _____ | _____ |
| 3.) _____ | _____ | _____ |
| 4.) _____ | _____ | _____ |
| 5.) _____ | _____ | _____ |

# ARC-Rheumatology History and Intake Form

**ONLY COMPLETE if you a PRIOR DIAGNOSIS of any of the following conditions: rheumatoid, psoriatic, ankylosing or gouty arthritis, lupus, Sjogren's, mixed connective tissue disease, scleroderma, vasculitis, fibromyalgia, osteoporosis**

| Medication | Month/Year started | Month/Year discontinued | Helped? Yes or No | Reason for discontinuation |
|---|---|---|---|---|
| Prednisone or Medrol | | | | |
| Plaquenil(hydroxychloroquine) | | | | |
| Sulfazalazine | | | | |
| Methotrexate: oral or SQ | | | | |
| Arava (leflunomide) | | | | |
| Azathioprine (Imuran) | | | | |
| Mycophenylate (Cellcept) | | | | |
| Cyclosphosphamide (Cytoxan) | | | | |
| Xeljanx | | | | |
| Otezla | | | | |
| Enbrel | | | | |
| Humira | | | | |
| Cimzia | | | | |
| Stelara | | | | |
| Consentrix | | | | |
| Simponi (Specify): SQ or IV | | | | |
| Orencia (Specify): SQ or IV | | | | |
| Actemra (Specify): SQ or IV | | | | |
| Remicade | | | | |
| Rituxan | | | | |
| Benlysta | | | | |
| Allopurinol | | | | |
| Uloric | | | | |
| Colchicine (Colcrys) | | | | |
| Neurontin (gabapentin) | | | | |
| Lyrica | | | | |
| Cymbalta (duloxetine) | | | | |
| Savella | | | | |
| Cyclobenzaprine (Flexeril) | | | | |
| Amitryptiline (Elavil) | | | | |
| Fosamax (alendronate) | | | | |
| Actonel | | | | |
| Boniva | | | | |
| IV Reclast (zolendronic acid) | | | | |
| Prolia | | | | |
| Forteo | | | | |

# ARC-Rheumatology History and Intake Form

## Social History

**Smoking Status (please choose one):**

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

**Alcohol Intake (please choose one):**

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day
- ☐ Illicit drug uses the past 12 months: No Yes
  Specify: _____

**Exercise Frequency (please choose one):**

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

**Sexual Status (please choose one):**

- ☐ Not sexually active
- ☐ Sexually active (One partner): ☐ Sexually active (multiple partners) ☐ Sexually active (same sex partner)

**How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks for women or any adult older than 65?** Select: 0 thru 365 days/year: _____

## Family History

Please include only first-degree relatives with rheumatic or arthritis diseases:

_____ _____

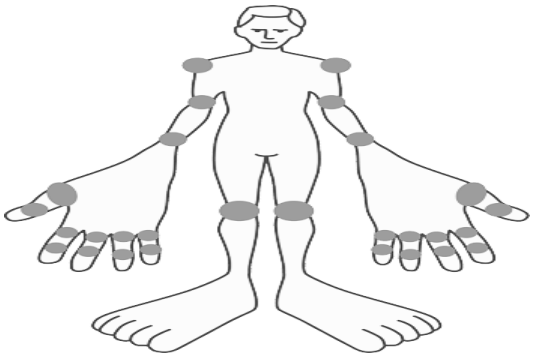
_____ _____

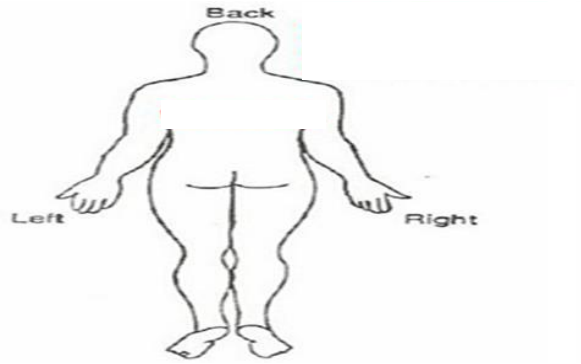
# ARC-Rheumatology History and Intake Form

1. CIRCLE **REASON FOR REFERRAL**: Osteoarthritis, Fibromyalgia, Rheumatoid arthritis, Psoriatic arthritis, Ankylosing spondylitis, Lupus, Sjogren's syndrome, Mixed or undifferentiated connective tissue disease, Dermatomyositis, Polymyositis, Osteoporosis, Vasculitis (Specify): _____; Abnormal autoimmune tests: Specify: _____
Other reason: _____

2. **IF PAIN IS YOUR CHIEF COMPLAINT** what is your **MOST** painful body site? _____

Place an **X** or **shade** the body locations in the diagram below all body sites where you are having **significant** pain or rash:






**Please circle and/or specify below all conditions that apply to you:**

**3. HAND DOMINANCE:** Right Left

**4. CONTEXT: PAIN ASSOCIATED WITH PRIOR INJURY OR REPETITIVE TASK**(Specify): _____

**5. QUALITY**: « aching » « acute» « acute on chronic» «chronic» « cramp like» « dull» « electric» «radiating» « sharp » «stabbing » « tender to touch» Other (Specify):_____

6. **ASSOCIATED SYMPTOMS**: «gait instability» «generalized muscle pain» «joint swelling» «muscle cramps» «rashes/redness»
**«Morning stiffness (Circle one)**: «none» «less than 20 min» «about 20-40 minutes» «More than 45 minutes»
Other(Specify): _____

7. **TIMIMG**: «occurs at night» «occurs in the morning» «occurs intermittently» «occurs with activity» Other:_____

8. **SEVERITY:** Currently: 0 (No pain) 1-3 (Mild), 4-6 (Moderate), 7-10(Severe)
Initially: 1-3 (Mild), 4-6 (Moderate), 7-10(Severe)

**9. DURATION**: Years: _____; Months: _____ Days: _____

10. **SPECIFY ANY TREATMENT THAT HAD HELPED:** «exercise» «joint injection» «muscle relaxants» «narcotics» «NSAIDs» «physical therapy» «topical gels» «Tylenol» «Ultram/Tramadol» Other (Specify): _____

11.. **REFERRING Doctor(s): What other specialist(s) have you seen for this problem**? _____

# ARC-Rheumatology History and Intake Form

## Review of Systems

## Alerts

**Please check yes for the following if it applies:**

| Symptom | Yes | Symptom | Yes |
|---|---|---|---|
| Excessive Fatigue | | Blood in urine | |
| Fever over 100F | | Genital ulcers | |
| | | Vaginal dryness | |
| Drenching night sweats | | Recurrent miscarriages | |
| Unintentional Weight Loss | | Excessive hair loss | |
| Eye Pain | | Rash with minimal sun exposure | |
| | | Other chronic recurrent rashes | |
| Excessive dry eyes | | Rosacea | |
| Excessive dry mouth | | Skin psoriasis | |
| Excessive tooth decay | | Excessive skin tightness | |
| Recurrent nose/mouth sores | | Finger/toes discoloration with cold | |
| Frequent nosebleeds | | Skin nodules | |
| Chronic sinusitis | | Scalp head tenderness | |
| Jaw achiness | | Extremity Tingling/numbness | |
| Ear lobe inflammation | | Extremity weakness | |
| Loud snoring | | Muscle twitches | |
| | | Drowsiness | |
| Chest pain w breathing | | Forgetfulness | |
| Swollen legs | | Depression | |
| Shortness of breath | | Anxiety/excessive stress | |
| Cough with blood | | Insomnia | |
| Persistent dry cough | | Heat intolerance | |
| Chronic heartburn | | Cold intolerance | |
| Swallowing difficulties | | Excessive bleeding | |
| Abdominal pain | | Swollen/tender glands | |
| Black stools | | Frequent infections | |
| Blood in stools | | | |
| Chronic diarrhea | | | |
| Chronic constipation | | | |
| Irritable bowel (IBS) | | | |

| Alert | Yes |
|---|---|
| Allergy to adhesive | |
| Allergy to Lidocaine | |
| Allergy to Topical Antibiotic ointments | |
| Pregnancy or planning Pregnancy | |
| Premedication Prior to Procedure | |
| Blood Thinners | |
| Artificial Heart Valve | |
| Artificial joints within past 2 years | |
| MRSA | |
| Pacemaker | |
| Defibrillator | |
| Problem with scarring | |