

**Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.*

Printed Patient Name: _____ Date of Birth: _____

Primary Medical Care Provider: _____

Referring Physician: _____

Occupation / Profession: _____

Birthplace: _____

Marital Status: Single Married Divorced Children: YES NO

REASON FOR VISIT: _____ Today's Date: _____

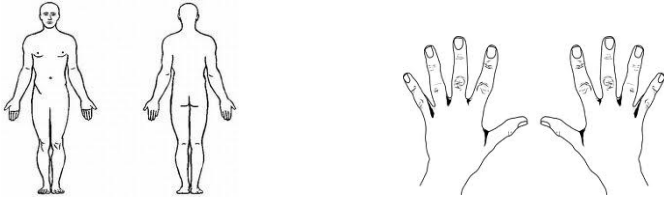
Describe present symptoms: _____

Date symptoms began: _____ Diagnosis: _____

Previous Treatment for this problem (include physical therapy, surgery, injections, etc.):

List other providers you have seen for this problem: _____

Mark all the locations of your pain over the last week on the body image and hands:



Rheumatologic History: (mark all that apply to you and any blood relative - provide relationship of relative)

Yourselves	Illness	Relative / Relationship	Yourselves	Illness	Relative / Relationship
<input type="checkbox"/>	Arthritis (unknown type)		<input type="checkbox"/>	Lupus or "SLE"	
<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>	Rheumatoid Arthritis	
<input type="checkbox"/>	Gout		<input type="checkbox"/>	Ankylosing Spondylitis	
<input type="checkbox"/>	Childhood Arthritis		<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	Autoimmune Disease: Type: _____		<input type="checkbox"/>	Psoriasis	

Have you ever fractured a bone: If yes, which bones: _____

Please list any surgeries you might have had: _____

Smoking History (Mark and Complete all that apply)

<input type="checkbox"/> Never Smoked	
<input type="checkbox"/> Quit Smoking	When - _____ Average Packs / Day _____

Do You Consume Alcohol? NO If Yes, List how much per week: _____

Do You Currently Exercise? NO If Yes, List Type and Duration: _____

How many hours do you sleep at night? ____ Do you wake up feeling reasonably well rested? _____

FOR WOMEN ONLY:

Number of Pregnancies: ____ Number of Miscarriages: ____ Have you had your ovaries removed: _____

If Post-Menopausal; Age when period stopped: ____ Have you been on hormone replacement: _____

MEDICATION ALLERGIES: No Known Allergies If yes, complete below:

Drug Name	Circle All That Apply to Each Drug			
	Rash	Hives	Shortness of Breath	Other -
	Rash	Hives	Shortness of Breath	Other -
	Rash	Hives	Shortness of Breath	Other -

Patient Printed Name: _____

Date of Birth: _____

CURRENT MEDICATIONS (also include aspirin, vitamins, calcium, and other supplements):

NAME	DOSE	FREQUENCY	INDICATION	DURATION OF TX

VACCINES RECEIVED: (Mark all that apply)

NAME	Administration Date	Result / Reaction if Any.
Flu Vaccine		
Pneumonia Vaccine		
PPD (TB test) / BCG		
Zostavax (Shingles Vaccine)		
Hepatitis B		

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	Genitourinary	Musculoskeletal
Unintended Weight Loss:	Pain with Urination	Joint Pain/Swelling (list joints)/area
Amount -	Frequent Urination	1.
How long -	History of Nephritis	2.
Unintended Weight Gain:	Blood in Urine	3.
Amount -	Kidney Stones	Muscle Weakness
How long -	Discharge from penis/vagina	Muscle Pains/Aches
Fatigue	Urinary Incontinence	Morning Stiffness- Hours:
Fever	Rash / Ulcers	Minutes:
Eyes	Gastrointestinal	Psychological
Pain	Nausea / Vomiting	Anxiety
Redness	Vomiting Blood	Depression
Loss of Vision	Difficulty Swallowing	Difficulty Falling Asleep
Dryness	Heartburn/Indigestion	Difficulty Staying Asleep
Ears-Nose-Mouth-Throat	Recent Abdominal Pain	Excessive Worries
Hoarseness	Chronic Constipation	Skin / Hair
Difficulty Swallowing Liquids	Chronic Diarrhea	Easy Bruising
Difficulty Swallowing Solids	Bloody/Black Stools	Rash
Severe Dryness of Mouth	Bowel Incontinence	Hives
Respiratory	Neurological	Sun Sensitive
Shortness of breath	Headaches	Skin Tightness
Difficulty breathing at night	Seizures	Hair Loss causing bald spots
Cough	Numbness/Tingling Hands Feet	Color Changes to Hands/Feet
Coughing up blood	Cardiovascular	Skin Ulcers
Wheezing	Chest Pain when inhaling	Spine
Hematology	Heart Murmurs	Chronic/Recurrent back pain
Swollen Glands	Swollen Legs or feet	Chronic/Recurrent neck pain
Anemia	Other Pertinent Medical History:	
Bleeding Tendency		
Transfusion:		
When:		
Clotting Tendency		

Patient Signature: _____

Date: _____

Print Patient Name: _____
 DOB: _____

Today's Date: _____

MULTI-DIMENSIONAL HEALTH ASSESSMENT QUESTIONS (Copyright Health Report Services)

1. Please answer the following questions to assess your abilities over the last week:

Were you able to:	Without Difficulty 0	With Some Difficulty 1	With Much Difficulty 2	Unable To Do 3
a. Dress yourself, including tying shoelaces and doing buttons?				
b. Get in and out of bed?				
c. Lift a full cup or glass to your mouth?				
d. Walk outdoors on flat ground?				
e. Wash and dry your entire body?				
f. Bend down to pick up clothing from the floor?				
g. Turn regular faucets on and off?				
h. Get in and out of a car, bus, train, or airplane?				
i. Walk two miles or three kilometers, if you wish?				
j. Participate in recreational activities and sports as you would like, if you wish?				
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

2. Over the past week, How much pain have you had because of your condition?

Indicate below how severe your pain has been. Circle the number that reflects your level of pain:

NO PAIN AS BAD AS
 PAIN 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0 IT COULD BE

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY VERY
 WELL 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0 POORLY

OFFICE USE ONLY

1. a-j FN (1-10) Score: _____	2. PN (1-10) Score: _____	3. PTGL (0-10) Score: _____
1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10.0		

