

PATIENT MEDICAL HISTORY CONTINUED

SURGERIES (Please mark all surgeries you have had)

	Month/Year		Month/Year
Appendectomy (Appendix) <input type="checkbox"/>	_____	Transplant (Specify: _____) <input type="checkbox"/>	_____
Cholecystectomy (Gallbladder) <input type="checkbox"/>	_____	Heart (Specify: _____) <input type="checkbox"/>	_____
Tonsillectomy <input type="checkbox"/>	_____	TURP <input type="checkbox"/>	_____
Adenoidectomy <input type="checkbox"/>	_____	Prostatectomy <input type="checkbox"/>	_____
Eyes (Specify: _____) <input type="checkbox"/>	_____	Knee Arthroscopy <input type="checkbox"/>	_____
Ears (Specify: _____) <input type="checkbox"/>	_____	Knee Replacement <input type="checkbox"/>	_____
Nose (Specify: _____) <input type="checkbox"/>	_____	Hip Replacement <input type="checkbox"/>	_____
Throat (Specify: _____) <input type="checkbox"/>	_____	Other Joint Replacement <input type="checkbox"/>	_____
Brain Surgery <input type="checkbox"/>	_____	Shoulder Surgery <input type="checkbox"/>	_____
Breast (Specify: _____) <input type="checkbox"/>	_____	Wrist Surgery <input type="checkbox"/>	_____
Colon/ Intestinal <input type="checkbox"/>	_____	Back Surgery (Specify: _____) <input type="checkbox"/>	_____
Hernia Surgery <input type="checkbox"/>	_____	Joint Fusion <input type="checkbox"/>	_____
Weight loss (Bypass/ Banding) <input type="checkbox"/>	_____	Spinal Fusion <input type="checkbox"/>	_____
Heart Valve Replacement <input type="checkbox"/>	_____	Coronary Artery Bypass Graft <input type="checkbox"/>	_____
Hysterectomy (Indicate type of Hysterectomy: Total or Partial / Abdominal or Vaginal) <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____

OTHER CONDITIONS

	Month/Year		Month/Year
Stroke <input type="checkbox"/>	_____	Tuberculosis (TB) <input type="checkbox"/>	_____
High Blood Pressure <input type="checkbox"/>	_____	Multiple Sclerosis <input type="checkbox"/>	_____
Heart Attack <input type="checkbox"/>	_____	Arthritis <input type="checkbox"/>	_____
Heart Disease <input type="checkbox"/>	_____	Rheumatoid Arthritis <input type="checkbox"/>	_____
High Cholesterol <input type="checkbox"/>	_____	Osteoarthritis <input type="checkbox"/>	_____
Congestive Heart Failure <input type="checkbox"/>	_____	Psoriatic Arthritis <input type="checkbox"/>	_____
Abnormal Heartbeat/ Palpitations <input type="checkbox"/>	_____	Osteoporosis <input type="checkbox"/>	_____
Blood Disease/Bleeding Disorder <input type="checkbox"/>	_____	Gout <input type="checkbox"/>	_____
Anemia <input type="checkbox"/>	_____	Fibromyalgia <input type="checkbox"/>	_____
Blood Clots <input type="checkbox"/>	_____	Lupus <input type="checkbox"/>	_____
Hardening of the Arteries <input type="checkbox"/>	_____	Kidney Disease <input type="checkbox"/>	_____
Treatment with Blood Thinner <input type="checkbox"/>	_____	Seizure Disorder (Epilepsy) <input type="checkbox"/>	_____
Diabetes (Circle: Type I/Type II) <input type="checkbox"/>	_____	Thyroid Disease <input type="checkbox"/>	_____
Asthma <input type="checkbox"/>	_____	Stomach Ulcer <input type="checkbox"/>	_____
Emphysema or COPD <input type="checkbox"/>	_____	Cancer (Specify: _____) <input type="checkbox"/>	_____
Hepatitis (Circle: Type B/Type C) <input type="checkbox"/>	_____	Depression <input type="checkbox"/>	_____
Exposure to/Positive for HIV <input type="checkbox"/>	_____	Antibiotic Treatment (past 2 mon.) <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____

Patient Name: _____
 WMG Account Number _____

FAMILY HISTORY

	Age	Health			Age at Death	Cause of Death
Father		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Mother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Brothers:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Sisters:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Maternal Grandfather		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Maternal Grandmother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Paternal Grandfather		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Paternal Grandmother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Spouse		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Sons:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Daughters:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		

Please list all family members effected by the following:

Family History Unknown

Adopted

M = Mother	MGM = Maternal Grandmother	MGF = Maternal Grandfather	F = Father	
PGM = Paternal Grandmother	PGF = Paternal Grandfather	B = Brother	S = Sister	O = Other immediate family
Alcohol Abuse _____			Hepatitis B _____	
Bleeding Disorder _____			Hepatitis C _____	
Blood Clots _____			Hypertension _____	
Cancer, Breast _____		Irritable Bowel Syndrome _____	Kidney Disease _____	
Cancer, Ovarian _____			Mental Illness _____	
Cancer, Lung _____			Osteoporosis _____	
Cancer, Prostate _____			Osteoarthritis _____	
Cancer, Stomach _____		Other Arthritis (Please specify) _____		
Cancer, Uterine _____		Pancreatitis _____		
Cancer, Colon _____		Rheumatoid Arthritis _____		
Cancer, Other _____		Seizure Disorders _____		
Crohn's Disease _____		Sickle Cell _____		
Diabetes _____		Stroke _____		
Liver Disease _____		Thyroid _____		
Gallstones _____		Tuberculosis (TB) _____		
Gout _____		Ulcer Disease _____		
Heart Attack _____		Ulcerative Colitis _____		
Heart Disease _____		Other _____		
Other _____		Other _____		
Other _____		Other _____		

Patient Name: _____
 WMG Account Number _____

RHEUMATIC DISEASE EVALUATION

Briefly describe your present symptoms: _____

When did you first notice your symptoms? _____

Do you have morning stiffness? _____ When did it begin? _____ How long does it last each day? _____

Do you become unusually fatigued during the day? _____ Every day? _____ At what time? _____

Does sunlight bother you or cause a rash? _____

Have you had any hair loss with these symptoms? _____

Do your hands turn blue/ white in cold weather? _____ Do you have dry eyes? _____ Dry mouth? _____

Please list the joints that have been involved: _____

Have you had joint injections? _____ Which joints? _____

Have you ever had a blood transfusion? _____ Have you had physical therapy? _____

List physicians, podiatrists, or chiropractors you have seen for arthritis and the approximate date of these evaluations: _____

Have you taken any of the following drugs?

- Circle the ones you have taken
- Check the following code boxes accordingly

Codes: E = Effective
 I = Ineffective
 SE = Side Effects / Adverse Effects

	E	I	SE		E	I	SE		E	I	SE
Analgesics – NSAIDs				Disease Modifiers (DMARDS)				Corticosteroids			
Ansaid, flurbiprofen				Arava, leflunomide				Prednisone,			
Aspirin				Azulfidine, sulfasalazine				Medrol, methylprednisolone			
Bextra, valdecoxib				Cytoxan, cyclophosphamide				Other Rheumatologics			
Celebrex, celecoxib				Gold (injection, pills)				Hyalgan, Supartz, hyaluronate			
Clinoril, sulindac				Imuran, azathioprine				Orthovisc, hyaluronan			
Daypro, oxaprozin				Dynacin, Minocin, minocycline				Synvisc, hylan GF 20			
Dolobid, diflunisal				Plaquenil, hydroxychloroquine				Osteoporosis/ Osteopenia			
Feldene, piroxicam				Rheumatrex, methotrexate				Actonel, risedronate			
Indocin, indomethacin				Biologics				Boniva, ibandronate			
Lodine, etodolac				Cimzia, certolizumab				Evista, raloxifene			
Mobic, meloxicam				Enbrel, etanercept				Forteo, teriparatide			
Motrin, Advil, ibuprofen				Humira, adalimumab				Fosamax, alendronate			
Naprosyn, Aleve, naproxen				Kineret, anakinra				Miacalcin, calcitonin			
Relafen, nabumetone				Orencia, abatacept				Reclast, zoledronic acid			
Tolectin, tolmetin				Remicade, infliximab				Hormones			
Voltaren, arthrotec, diclofenac				Rituxan, rituximab				Estrogen, progesterone			
Vioxx, rofecoxib				Simponi, golimumab				testosterone			
Analgesics – Narcotics				Gout				Muscle Relaxants			
Darvon, Darvocet, propoxyphene				Colchicine				Flexeril, cyclobenzaprine			
Demerol, meperidine				Probenicid				Norflex, orphenadrine			
Dilaudid, hydromorphone				Uloric, febuxostat				Skelaxin, metaxalone			
Duragesic, fentanyl				Zyloprim, allopurinol				Soma, carisoprodol			
Vicodin, Lortab, Lorcet, hydrocodone				Other Neurologics				Zanaflex, tizanidine			
MS Contin, morphine				Provigil, modafinil				Sjögren’s Syndrome			
OxyContin, Percocet, oxycodone				Antidepressants				Evoxac, cevimeline			
Tylenol #2, #3, #4, codeine				Cymbalta, duloxetine				Lacrisert, hydroxypropyl cellulose			
Analgesics - Other				Desyrel, trazodone				Restasis, cyclosporine			
Tylenol, acetaminophen				Effexor, venlafaxine				Salagen, pilocarpine HCl			
Ultram, Ultracet, tramadol				Elavil, amitriptylene				Anti-Parkinsonians			
Zostrix, capsaicin cream				Lexapro, escitalopram				Mirapex, pramipexole			
Anti-convulsants				Lyrica, pregabalin				Sinemet, carbidopa/levodopa			
Neurontin, gabapentin				Pamelor, nortriptylene				Immunosuppressants			
Topamax, topiramate				Pristiq, desvenlafaxine				CellCept, mycophenolate mofetil			
				Prozac, fluoxetine				Neoral, cyclosporine			

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**FUNCTIONAL EVALUATION:
 MODIFIED HEALTH ASSESSMENT QUESTIONNAIRE (mHAQ)**

mHAQ scoring (office use only)
 Formula: Total score = number of answered questions = mHAQ

Please mark the one response that best describes your usual abilities over the past few days:	Without ANY Difficulty (0)	With SOME Difficulty (1)	With MUCH Difficulty (2)	UNABLE to do (3)
1) Dress yourself, including tying shoelaces and fastening buttons?				
2) Get in and out of bed?				
3) Lift a full cup/glass to your mouth?				
4) Walk outdoors on flat ground?				
5) Wash and dry your entire body?				
6) Bend down and pick up clothing from the floor?				
7) Turn water faucets on and off?				
8) Get in and out of the car?				

On a scale of 1-10, how would you rate your PAIN?

None |-----|-----|-----|-----|-----|-----|-----|-----| Severe
 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how would you rate your FATIGUE?

None |-----|-----|-----|-----|-----|-----|-----|-----| Severe
 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how would you rate your DISEASE ACTIVITY?

None |-----|-----|-----|-----|-----|-----|-----|-----| Severe
 0 1 2 3 4 5 6 7 8 9 10

Circle either YES or NO

PLEASE DO NOT WRITE IN SPACE BELOW

YES NO Have you had fever or chills recently?
 YES NO Do you have frequent headaches?
 YES NO Have you ever had a convulsion, fit, or epilepsy?

GNL

YES NO Have you had a rash or other skin problems?

INT

YES NO Have you had red or inflamed eyes?
 YES NO Have you had pain or ringing in your ears?
 YES NO Do you have trouble swallowing?

EENT

YES NO Have you ever had shortness of breath?
 YES NO Do you have a chronic cough?

RES

YES NO Have you ever had chest pain or tightness in your chest?
 YES NO Have you had a heart attack? (In what year(s): _____)

CV

YES NO Do you frequently have stomach upsets?
 YES NO Have you had any recent changes in your bowel habits?
 YES NO Have you ever had an ulcer? (In what year(s): _____)
 YES NO Have you had intestinal bleeding, black, or tarry stools?

GI

YES NO Have you had recent frequency or burning with urination?
 YES NO Do you get up frequently at night to urinate? (How many times? _____)
 YES NO Have you ever passed a kidney stone? (In what year(s): _____)

GU

YES NO Are you more sensitive to cold exposure than others in the same area?

END

YES NO Have you been nervous or depressed? (circle if applicable)

PSY

To be answered by WOMEN ONLY:

GYN

YES NO Has there been a change in frequency or amount of your menstrual flow?
 Date of last period? _____
 Date of last pap smear (cancer test)? _____
 Date of last DEXA or Osteoporosis screening? _____
 Number of pregnancies? _____
 Number of children born alive? _____