



AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: Time of appointment: Birthplace:

Name: LAST FIRST MIDDLE INITIAL MAIDEN Birthdate:

Address: STREET APT# Age: Sex: F M
CITY STATE ZIP Telephone: Home Work

MARITAL STATUS: Never Married Married Divorced Separated Widowed
Spouse/Significant Other: Alive/Age Deceased/Age Major Illnesses

EDUCATION (select highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School
Occupation Number of hours worked/average per week

Evaluation request by: (check one) Self Family Friend Doctor Other Health Professional

Name of person requesting consult

The name of the physician providing your primary medical care:

Do you have an orthopedic surgeon? Yes No If yes, Name:

Describe briefly your present symptoms:

Date symptoms began (approximate):

Diagnosis:

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

Please list the names of other practitioners you have seen for this problem:

Please shade all the locations of your pain over the past week on the body figures and hands.
Example:
LEFT RIGHT LEFT RIGHT

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Table with 6 columns: Yourself, Relative Name/Relationship, Yourself, Relative Name/Relationship. Rows include Arthritis (unknown type), Osteoarthritis, Gout, Childhood arthritis, Lupus or "SLE", Rheumatoid Arthritis, Ankylosing Spondylitis, Osteoporosis.

Other arthritis conditions: