AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ○ F ○ M
STREET APT#

_____ Telephone: Home _____
CITY STATE ZIP 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):

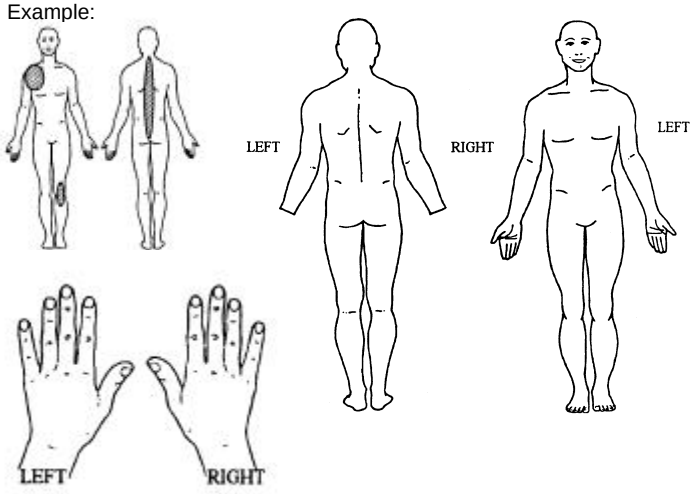
_____

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:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
☐	Arthritis (unknown type)		☐	Lupus or "SLE"	
☐	Osteoarthritis		☐	Rheumatoid Arthritis	
☐	Gout		☐	Ankylosing Spondylitis	
☐	Childhood arthritis		☐	Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____