SAHNI RHEUMATOLOGY & THERAPY

Patient History Form

Name:_____ Birthdate:____/____/____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

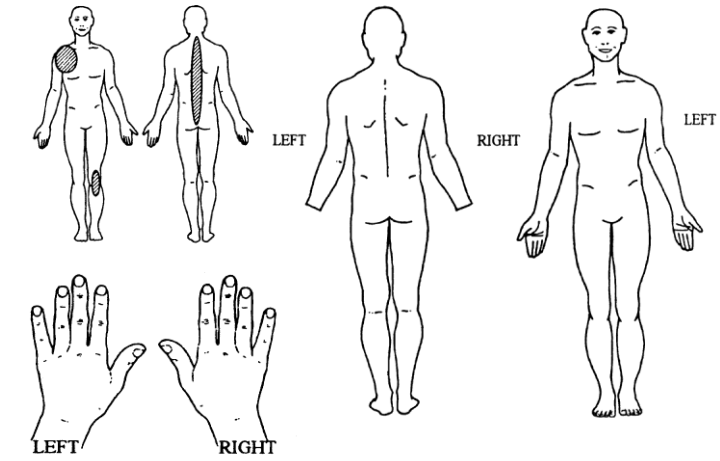
Date symptoms began (approximate):_____

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**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATOLOGIC HISTORY

ACTIVITIES OF DAILY LIVING

Because of health problems, do you have difficulty: (Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Dressing yourself?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐

What is the hardest thing for you to do?_____

Are you applying for disability? Yes ☐ No ☐

Are you receiving disability? Yes ☐ No ☐

➔ If yes, for what diagnosis(es)? _____

Do you have a medically related lawsuit pending? Yes ☐ No ☐

MEDICATIONS

Drug allergies: ☐ No ☐ Yes → What drug and reaction? _____

_____

_____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
11.			☐	☐	☐
12.			☐	☐	☐
13.			☐	☐	☐
14.			☐	☐	☐
15.			☐	☐	☐
16.			☐	☐	☐
17.			☐	☐	☐
18.			☐	☐	☐
19.			☐	☐	☐
20.			☐	☐	☐

PAST SURGICAL HISTORY

Year	Procedure

SOCIAL HISTORY

Do you smoke? _____ Yes _____ No If yes, how many a day? _____ For how many years? _____

Do you drink alcohol? _____ Yes _____ No If yes, how many a day? _____ For how many years? _____

Occupation(s): _____

FAMILY HISTORY *(only list those with illness)*

	Gout	Psoriasis	RA	Lupus	Cancer (type)	Heart Disease
Father						
Mother						
Grandfather						
Grandmother						
Siblings						
Siblings						
Children						

SYMPTOM	*SIDE OF THE BODY* *CHECK BOTH IF APPROPRIATE*	
	RIGHT SIDE	*LEFT SIDE*
BACK PAIN		
PAIN IN YOUR LOWER BACK		
PAIN IN YOUR BUTTOCKS		
LEG PAIN		
PAIN OR BURNING IN YOUR LEGS		
NUMBNESS OR TINGLING IN YOUR LEGS		
WEAKNESS IN YOUR LEGS		
LOSS OF STRENGTH IN YOUR LEGS		
FOOT PAIN		
PAIN OR BURNING IN YOUR FEET		
NUMBNESS OR TINGLING IN YOUR FEET		
PINS AND NEEDLES IN YOUR FEET		
INCREASED SENSITIVITY TO TOUCH ON YOUR FEET (FOR EXAMPLE IT HURTS WHEN BED COVER)		
TROUBLE FEELING HOT AND COLD IN YOUR FOOT		
DISCOMFORT OR PAIN AT NIGHT IN YOUR FEET		
NECK, HANDS, FINGER OR WRIST PAIN		
BURNING IN YOUR FINGERS		
NUMBNESS OR TINGLING IN YOUR HANDS		
DIFFICULTY GRIPPING THINGS WITH YOUR HANDS		
DIFFICULTY FORMING A FIST WITH YOUR HAND		
DISCOMFORT IN HANDS WAKES YOU AT NIGHT		
PAIN IN YOUR NECK		

☐ **I HAVE NONE OF THE SYMPTOMS LISTED ABOVE**

DO YOU HAVE DIABETES?

YES	**NO**

PATIENT SIGNATURE _____ DATE_____