THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – Rheumatology

PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY AND BRING TO YOUR APPOINTMENT.

Date of first appointment ____/____/____ Birthplace _____

Name: _____ ___ Date of Birth ____/____/____

Last First MI Maiden Mo Day Yr

Street Address: _____ Age: _____

City: _____ State: _____ Zip: _____ Gender: Male Female

Telephone: Home (_____) _____-_____ Work (_____) _____-_____

Referred by (circle one): Doctor Self Family Friend Other Health Professional

Name of person making referral: _____

For the doctor who referred you, please provide the following:

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: Office (_____)_____-_____ Fax (_____) _____-_____

For your primary care physician, please provide the following:

Name: _____

Street Address: _____

City: _____ State:_____ Zip:_____

Telephone: Office (_____)_____-_____

Briefly describe your present symptoms:

_____

_____

_____

Date symptoms began (approximate): _____ Diagnosis given? _____

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

_____

_____

_____

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

_____

Rheumatologic (Arthritis) History:

At any time have you or a blood relative had any of the following (please list relationship):

Arthritis _____ Lupus or "SLE" _____

Osteoarthritis _____ Gout _____

Ankylosing Spondylitis _____ Osteoporosis _____

Rheumatoid Arthritis _____ Childhood Arthritis _____

Other Arthritis Conditions _____

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Systems Review: As you review the following list, please check any of those problems that apply to you:

General:
Recent Weight Gain – amount _____
Recent Weight Loss – amount _____
Fatigue
Weakness
Fever
Night Sweats

Nervous System:
Headaches
Dizziness
Fainting
Muscle Spasm
Loss of Consciousness
Numbness or tingling of hands and/or feet
Memory Loss

Ears:
Ringing in ears
Loss of hearing

Eyes:
Pain
Redness
Loss of vision
Double vision
Blurred visions
Dryness

Nose:
Dryness
Nosebleeds
Loss of smell

Mouth:
Dryness
Sore tongue
Bleeding gums
Sores in mouth
Loss of taste

Throat:
Difficult swallowing
Frequent sore throats
Hoarseness

Heart/Lungs:
Pain in chest
Irregular heartbeat
Sudden Changes in Heartbeat
Shortness of breath
Swollen legs or feet
High Blood Pressure
Heart Murmurs
Cough
Coughing of Blood
Wheezing

Stomach/Intestines:
Nausea
Vomiting of blood or coffee ground material
Stomach pain relieved by food or milk
Yellow jaundice
Increasing constipation
Persistent diarrhea
Blood in stools
Black stools
Heartburn

Kidney/Urine/Bladder:
Difficult urination
Pain/burning on urination
Blood in urine
Cloudy, "smoky" urine
Discharge from penis/vagina
Frequent urination
Getting up at night to pass urine, # of times _____
Vaginal dryness
Rash/ulcers
Sexual difficulties
Prostate trouble
Sexual transmitted disease

Blood:
Anemia
Bleed tendency

Skin:
Easy bruising
Redness
Rash
Sun sensitive
Hives
Tightness
Nodules/bumps
Color change of hands/

Muscle/Joints/Bones
AM stiffness lasting how long: min ____ hrs ____
Joint Pain
Muscle Weakness
Muscle Soreness
Joint Swelling

Mark Joints Affected In The Last Six (6) Months:

Jaw	Shoulders
Elbows	Wrists
Thumbs	Fingers
Hips	Knees
Ankles	Feet
Neck	Upper back
Middle back	Lower back

Habits:
Please circle Yes or No
Drink coffee? Yes No
Cups per day _____
Do you smoke? Yes No
Cigarettes per day: _____
Drink alcohol? Yes No
Drinks per day: _____
Illegal drugs: Yes No
If so, list: _____
How many pillows do you use to sleep on? _____
Do you get enough sleep at night? Yes No
Do you wake up feeling rested? Yes No

Menstrual:
Age periods began _____
Periods regular: Yes No
How many days apart: __
Beginning of last period
_____/_____/_____
Last Pap smear (mo/yr):
_____/_____/_____
Bleeding after menopause?

Obstetrical:
# of living children _____
# of pregnancies_____ _
# of miscarriages _____

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Past Personal History (do you have or have you had):

High blood pressure	Jaundice	Bad Headaches	Diabetes
Cancer	Nervous breakdown	Pneumonia	Goiter
Stroke	Psoriasis	Heart problems	Rheumatic fever
Leukemia	Asthma	Stomach ulcers	Kidney disease
Epilepsy	Cataracts	Colitis	Alcoholism
Anemia			

Other significant illnesses (please list):

_____
_____

Please list any medications to which you appear to be allergic (please indicate type of reation):

_____
_____

Previous Operations: **Yes** **No** **If yes, please list type and approximate year:**

Type Year Type Year

_____
_____
_____
_____

Any previous fractures: No Yes (please describe): _____
Any other serious injuries: No Yes (please describe): _____

Family History:

Parent	*Age*	*Health*	*Age at Death*	*Cause*
Father				
Mother				
Relations	*Age*	*Health*	*Age at Death*	*Cause*
Brothers				
Sisters				
Children				

Current Ages of Children:
Males _____
Females _____

Any serious illnesses (please list)?

_____
_____

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Do you know of any blood relative who has or had the following (please mark and indicate the relationship):

Cancer _____ High Blood Pressure _____
Asthma _____ Bleeding Tendency _____
Leukemia _____ Tuberculosis _____
Stroke _____ Alcoholism _____
Diabetes _____ Colitis _____
Goiter _____ Rheumatic Fever _____
Epilepsy _____ Heart Disease _____

Marital Status:

Never Married Married Divorced Separated Widow/widower

Home Conditions:

House Apartment
Do you have stairs to climb: No Yes (how many): _____
Number of people in household: _____
Relationship and age of each:
_____
_____

Current overall level of function:

On the scale below, circle a number which best describes your situation. Most of the time, I function:

VERY WELL 1 2 3 4 5 6 7 8 9 10 VERY POORLY

Education (circle the highest level attended):

Grade school (K-6)
Junior High School: 7 8 9
Senior High School: 10 11 12
College: 13 14 15 16 **Degree:** _____
Graduate School: 17 18 19 20 21 22 **Degree:** _____

Occupation **(current) :** _____
Occupation **(former):** _____
Retired (please give approximate month and year): _____/_____
Disabled (please give approximate month and year): _____/_____
Please give reason for disability: _____

Reviewed By: _____
Fellow/Resident/Nurse Specialist/Medical Student

_____ MD
Attending Physician