marinhealth℠ Medical Network | UCSF Health

RHEUMATOLOGY

Health History

Date of first appointment: ______________________________

Your full name: ______________________ M_____ F_____ Birthday: ______________

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Primary care physician: ______________________________

Specialists you see: ______________________________

Briefly describe the medical condition/symptom that has brought you to our office:

____

____

Have you had any treatment for this problem? (physical therapy, medications, injections)

____

____

Please list other major illnesses or conditions for which you have received treatment (current and past). Exclude surgeries.

Year	Illness	Treatment

State type and approximate date of any surgeries you have had:

Year	Reason	Hospital

Social History

Do you drink caffeinated beverages? ☐ yes ☐ no – cups per day?________

Do you smoke? ☐ yes ☐ no ☐ past – how long ago? ______________________________

Do you drink alcohol? ☐ yes ☐ no – number per week? ______________________________

Do you exercise regularly? ☐ yes ☐ no Type of exercise______________________________

Amount of exercise per week ______________________________

Do you get enough sleep at night? ☐ yes ☐ no

What is your occupation? ______________________________

Are you disabled? _________ Describe ______________________________

LAST NAME, FIRST: ______________________________

Medications

Name of drugs you are NOW taking, include vitamins, supplements and over the counter products.

Medication	Dose	Frequency

Drug Allergies

Medication	Reaction

Have you taken any of these medications in the past?

- ☐ Advil/Motrin (ibuprofen)
- ☐ Aleve (naproxen)
- ☐ Allopurinol
- ☐ Arava (leflunomide)
- ☐ Azulfadine (sulfasalazine)
- ☐ Celebrex
- ☐ Cellcept
- ☐ Colchicine
- ☐ Cyclobenzaprine
- ☐ Darvocet (propoxyphene)
- ☐ Diclofenac
- ☐ Enbrel
- ☐ Humira
- ☐ Imuran (azathioprine)
- ☐ Medrol
- ☐ Methotrexate
- ☐ Plaquenil (hydroxychloroquine)
- ☐ Prednisone
- ☐ Probenecid
- ☐ Remicade
- ☐ Rituxan
- ☐ Tylenol (acetaminophen)
- ☐ Tylenol /codeine
- ☐ Ultram (tramadol)
- ☐ Vicodin (hydrocodone)
- ☐ Other ______________________________

____

LAST NAME, FIRST: ______________________________

Family History

Family Member	Age	If living, describe health	If deceased, describe cause	Age at death
Father				
Mother				
Brothers				
Sisters				
Children				

Diseases in Your Family

Disease	Reaction	Disease	Relationship
Diabetes		Lupus	
Tuberculosis		Psoriasis	
Hypertension		Hay fever	
Stroke		Kidney stones	
Heart disease		Migraines	
Cancer		Epilepsy	
Gout		Alcoholism	
Asthma		Thyroid	
Rheumatoid arthritis		Colitis	
Other arthritis		Abnormal bleeding	

LAST NAME, FIRST: ______________________________

General Health

General
- [ ] Recent weight loss
- [ ] Fatigue
- [ ] Weakness
- [ ] Fever

EENT
- [ ] Loss of vision
- [ ] Head pain or eye pain
- [ ] Headaches
- [ ] Jaw pain
- [ ] Dry eyes
- [ ] Dry mouth
- [ ] Eye inflammation
- [ ] Ringing in ears
- [ ] Sores in mouth
- [ ] Swollen glands

Skin
- [ ] Facial rash
- [ ] Loss of hair
- [ ] Hives
- [ ] Color change in extremities in cold
- [ ] Skin tightening
- [ ] Skin ulcers
- [ ] Psoriasis
- [ ] Abnormal nails
- [ ] Other rashes
- [ ] Recent tick bite
- [ ] Easy bruising

Heart and Lungs
- [ ] Pain with breathing
- [ ] Irregular heartbeat
- [ ] Pain in chest
- [ ] Shortness of breath
- [ ] Swollen legs or feet
- [ ] Cough/wheezing
- [ ] Leg pain when walking
- [ ] High blood pressure

Gastrointestinal
- [ ] Loss of appetite
- [ ] Nausea
- [ ] Abdominal pain
- [ ] Blood in stools
- [ ] Bleeding from intestinal tract
- [ ] Diarrhea
- [ ] Constipation
- [ ] Gastric ulcer
- [ ] Duodenal ulcer
- [ ] Trouble swallowing
- [ ] Peptic ulcer symptoms

Metabolic/Endocrine
- [ ] Gout or high uric acid
- [ ] Kidney stones
- [ ] Diabetes
- [ ] Thyroid disorder

Hematologic/immunologic
- [ ] Anemia
- [ ] Low platelet count
- [ ] Abnormal bleeding bruising
    - [ ] Transfusions
    - [ ] Frequent infections
- [ ] Skin test for TB
    - [ ] Positive
    - [ ] Negative
- [ ] Hayfever
- [ ] Contact allergies
- [ ] Food allergies

Neuromuscular/psychiatric
- [ ] Seizure
- [ ] Numbness
- [ ] Paralysis or stroke
- [ ] Tremor
- [ ] Muscle weakness
- [ ] Muscle pain
- [ ] Depression
- [ ] Psychiatric illness

Genitourinary
- [ ] Burning or frequency on urination
- [ ] Urinary infections
- [ ] Protein or albumin in urine
- [ ] Abnormal kidney function
- [ ] Discharge from urethra
- [ ] Difficulty with sexual function

For Women Only
- [ ] Breast abnormality or discharge
- [ ] Menstrual abnormality
- [ ] Pregnancies, total
- [ ] Pregnancies, failed
- [ ] Age at menopause

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