Ortho Nebraska
Rheumatology

Date of
Appointment _____

AGE_____YEARS SEX___F___M NAME_____ DOB_____
FIRST MIDDLE LAST

BIRTHPLACE_____ MARITAL STATUS _____ RELIGION _____
REFERRING DOCTOR _____ ADDRESS _____ PHONE _____
FAMILY DOCTOR _____ ADDRESS _____ PHONE _____
ORTHOPEDIC SURGEON _____ ADDRESS _____ PHONE _____
GYNECOLOGIST _____ ADDRESS _____ PHONE _____
PHARMACY _____ ADDRESS _____ PHONE_____

Family History

	IF LIVING			IF DECEASED	
	SEX	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS/SISTERS					
SPOUSE					
SONS/DAUGHTERS					

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS HAD: (CIRCLE AND GIVE RELATIONSHIP)
STROKE_____ TUBERCULOSIS _____BLOOD DISEASE _____ ASTHMA _____
HIGH BLOOD PRESSURE _____ BLEEDING TENDENCY _____ EPILEPSY _____
HEART ATTACK _____ DIABETES _____
KIDNEY DISEASE _____ GOUT _____ "ARTHRITIS" _____
If diagnosed by a doctor, is it:

RHEUMATOID ARTHRITIS _____ OSTEOARTHRITIS _____ OSTEOPOROSIS _____
CANCER _____ If yes, what kind? _____ PROBLEMS WITH BACK _____

PERSONAL HISTORY

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? ( ) YES ( ) NO If Yes, please provide a copy for our records.
PRESENT OCCUPATION _____ Are you working now? _____ Full/Part Time _____
PAST OCCUPATION _____Unable to work since: _____
SPORTS OR HOBBIES _____
MILITARY SERVICE _____
HAVE YOU EVER SMOKED? _____ cigarettes _____ pipe _____ cigars _____how many per day? _____
For how many years? _____ How long ago did you quit? _____
DO YOU REGULARLY DRINK ALCOHOL? _____ occasionally? _____ Is alcohol a problem for you?_____
WHERE HAVE YOU LIVED? (geographically) _____
DESCRIBE YOUR CURRENT RESIDENCE: Apartment _____ Home (how many levels) _____
Where is your bedroom/bathroom in the home? _____
CURRENT LIVING SITUATION: (example – self, w/children, w/significant other? _____
WHICH OF THE FOLLOWING DO YOU USE? Cane_____ Walker _____ Electric Cart _____
Standard Wheelchair _____ Toilet Riser _____
WHAT IS THE MOST DIFFICULT THING FOR YOU TO DO AT HOME? _____

Please list any children and their ages:

	Name	Age
1		
2		
3		
4		

PAST HISTORY

Record the diseases, surgeries, and injuries you have had:

Name of Illness or Surgery	Date	Age	Name of Illness or Surgery	Date	Age
Medical Diseases:			**Operations:**		
High Blood Pressure					
Diabetes (Age of Onset)					
Cancer					
Ulcer					
Heart Disease					
Blood Clots			**Injuries:**		
Others:					
			Fractures		
			Major Accidents		

NAME ANY DRUG THAT YOU ARE ALLERGIC TO:

Name of Drug _____ Describe Reaction _____

_____

_____

Describe any other allergies you have _____

_____

How is your appetite? (Circle One) Good Fair Poor

Have you gained_____ or lost _____ weight _____lbs. In _____months? _____

Are you on a special diet? _____ If so What kind? _____

_____

SYMPTOMS/COMPLAINTS

When did you first notice your symptoms? _____

Is your Symptoms/Complaints accident related? ( ) Yes ( ) No If Yes please answer the below questions:

Date of Accident_____ Details of Accident (car, type of injury, etc)_____

_____

Do you have morning stiffness? _____ For how long? _____ Where? _____

Do you become unusually fatigued in the afternoon or evening? _____ At what time? _____

Does sunlight bother you or cause a rash? _____Do your hands get blue or white with cold? Yes_____ No _____

Have you had hair loss? _____ Do you have significantly dry eyes? _____Mouth? _____

Please list the joints which have been involved: _____

_____

List names of physicians, podiatrists, or chiropractors you have seen for arthritis and the approximate date of these evaluations:

_____

Any Joint Injections?_____ Which Joints?_____

Have you had physical therapy?_____ Specifically for arthritis?_____ When?_____

Did it help?_____

Have you taken any of the following drugs?

Circle the ones you have taken	**When?** (approx. date)	**Effective?/Side Effects?**
Actemra		
Ansaid (Flurbiprofen)		
Arava		
Aspirin (Anacin, Ascriptin, Bufferin, Ecotrin)		
Atlevia, Actonel, Fosamax		
Benlysta, Krystexxa		
Boniva, Reclast, Forteo, Prolia		
Calcium or Vitamin D		
Celebrex		
Clinoril (Sulindac)		
Codeine, Vicodin (Hydrocodone), Lortab, Lorcet		
Colchicine, Colcrys, Benemid, Colebenemid		
Daypro (Oxaprozin)		
Disalcid, Salsalate, Monogesic, Trilisate		
Dolobid (Diflunisal)		
Duexis, Vimovo		
Estrogens (Premarin, Estrace, Ogen, Evista)		
Evoxac		
Feldene (Piroxicam)		
Gold (Myochrysine): Injection Pills		
Humira, Simponi, Cimzia, Enbrel		
Hyalgan, Synvisc, Orthovisc		
Imuran (Azathioprine)		
Indocin (Indomethacin)		
Kineret		
Lodine (Etodolac)		
Lyrica, Cymbalta, Savella		
Miacalcin (Nasal Calcitonin)		
Methotrexate, Rheumatrex		
Mobic (Meloxicam)		
Motrin, Nuprin, Advil (Ibuprofen)		
Muscle Relaxants (Soma, Norflex, Flexeril, Parafon, Cyclobenzaprine)		
Naprosyn, Anaprox, (Naproxen), Aleve		
Neurontin (Gabapentin), Gralise		
Numoisyn		
Nuvigil		
Orencia (IV or Injectable)		
Orudis (Ketoprofen), Oruvail, Orudis-KT		
Penicillamine (Depen, Cuprimine)		
Plaquenil		
Prednisone, Medrol, Cortisone, Rayos		
Relafen (Nabumetone)		
Remicade		
Rituxan, Cytoxan		
Sulfasalazine (Azulfidine)		
Tolectin (Tolmetin)		
Toradol (Ketorolac)		
Tylenol, Anacin-3, Acetaminophen		
Tylox, Percodan, Demerol, Talwin		

Uloric		
Ultram		
Voltaren (Diclofenac), Cataflam, Arthrotec		
Xeljanz, Stelara		
Zostrix Cream (Capsaicin), Dolorac, Mobisyl		
Zyloprim (Allopurinol)		

DESCRIBE BRIEFLY YOUR PRESENT SYMPTOMS: _____

_____

_____

_____

_____

_____

ON A SCALE OF 1 TO 10 HOW WOULD YOU RATE YOUR PAIN?

NONE I-----I-----I-----I-----I-----I-----I-----I-----I-----I MOST SEVERE

1 2 3 4 5 6 7 8 9 10

(Circle symptoms you have had)

1) Fever Chills Fatigue Weight Gain Weight Loss

2) Blindness Blurred Vision Dry Eyes Eye Redness

3) Decreased Hearing Difficulty swallowing Jaw Pain Ringing in Ears Mouth Sores

4) Shortness of Breath Cough Coughing up Blood Wheezing

5) Chest Pains Palpitations Poor Circulation or Change in Color of Extremities

6) Nausea Vomiting Diarrhea Constipation Heartburn Abdominal Pain
Change in Bowel Habits Rectal Bleeding

7) Painful Urination Blood in Urine Awakening at Night to Urinate Urinary Frequency
Urinary Retention Urinary Urgency

8) Bruising Tendency Bleeding Tendency

9) Recurrent Infections

10) Back Pain Joint Pain Muscle Spasms Muscle Weakness Joint Stiffness
Joint Swelling

11) Rash Itching of skin

12) Numbness Tingling Dizziness Headache Memory Loss

13) Anxiety Depression Sleeping Problems

14) Hair Loss

To be answered by women only:

14) Abnormal Period Absence of Period Abnormal Flow

Date of last period? _____

Date of last pap smear? _____

Dexa or osteoporosis screen? _____

If yes, date? _____, where? _____

Number of pregnancies? _____

Number of children born alive? _____

Health Promotion

Immunizations – Have you received your:

Influenza Vaccine If yes, when?

Yes No Unknown _____

Pneumococcal Vaccine If yes, when?

Yes No Unknown _____

Shingles Vaccine If yes, when?

Yes No Unknown _____

COVID Vaccine

Yes – Series Started Yes – Series Completed No Declined

If yes, when? _____ What brand? _____

Have you had your booster? Yes No

If yes, when? _____ What brand? _____

Are you 64 years of age or older? Yes No

Advanced Care Planning and Fall Prevention:

Do you have an Advance Directive? Yes No

Are you providing a copy of your Advance Directive at your visit? Yes No

Are you interested in receiving additional information on Advance Directive? Yes No

Are you non-ambulatory (wheelchair bound or bedridden)? Yes No

Have you fallen in the past year? Yes No If yes how many times? _____ Were you injured? Yes No

Do you feel unsteady standing or walking? Yes No

Do you worry about falling? Yes No

Patient/Guardian Signature

_____ _____

Signature Date

Ortho Nebraska
Rheumatology

PLEASE LIST ALL CURRENT MEDICATIONS

Please list all medications (even over-the-counter medications and herbal supplements). Note all strengths and dosages.

_____

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