ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

Today's Date:

ILLINOIS BONE AND JOINT INSTITUTE

Rheumatology Medical History Form

Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Street Address:	**City:**	**State:**	**Zip Code:**
Home Telephone:	**Work Telephone:**		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Referring doctor:			

PERSONAL HEALTH HISTORY

Briefly state your reason for seeing the doctor today. Please describe your current symptoms, when it started, and what you have done for it:

REVIEW OF SYSTEMS

Please check mark whether you have had any of the conditions listed below over the LAST MONTH

	Constitutional		**Respiratory**		**Neurological**
	☐ Fever		☐ Shortness of breath		☐ Dizziness
	☐ Weight gain (>10 lbs)		☐ Wheezing		☐ Losing your balance
	☐ Weight loss (>10 lbs)		☐ Cough		☐ Numbness or tingling or arms or legs
	☐ Feeling sickly		**Gastrointestinal**		☐ Weakness
	☐ Fatigue		☐ Loss of appetite		**Musculoskeletal**
	Head/Eye/Ear/Nose/Throat		☐ Heartburn or stomach gas		☐ Muscle pain, aches, or cramps
	☐ Headaches		☐ Stomach pain or cramps		☐ Swelling of hands
	☐ Dry eyes		☐ Nausea		☐ Swelling in other joints
	☐ Blurred vision		☐ Vomiting		☐ Joint pain
	☐ Wear glasses/contacts		☐ Constipation		☐ Back pain
	☐ Problems with hearing		☐ Diarrhea		☐ Neck pain
	☐ Ringing in the ears		☐ Dark or bloody stools		**Skin**
	☐ Stuffy nose		**Genitourinary**		☐ Rash
	☐ Sores in the mouth		☐ Problems with urination		☐ Hair changes
	☐ Swollen glands		☐ Gynecological (female) problems		☐ Nail changes
	☐ Dry mouth		☐ Blood in urine		**Psychiatric**
	☐ Lump in your throat		☐ Sexual problems		☐ Depression-feeling blue
	☐ Problems with smell or taste		**Endocrine**		☐ Anxiety-feeling nervous
	☐ Trouble swallowing		☐ Excessive urination		☐ Problems with thinking
	Cardiovascular		☐ Heat/cold intolerance		☐ Problems with sleeping
	☐ Pain the chest		**Hematologic**		☐ Problems with memory
	☐ Heart pounding (palpitations)		☐ Easy bruising		☐ Other problems:
	☐ Swelling		☐ Easy bleeding		

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you

1. Please check (✓) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like?	0	1	2	3
Get a good night's sleep?	0	1.1	2.2	3.3
Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY	
1. a-j **FN** (0-10)	
1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10
2. PN (0-10)	
4. PTGL (0-10)	
RAPID 3 (0-30)	
Cat:	
HS=	>12
MS=	6.1-12
LS=3.1-6	**R**=≤3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN ☐ 0 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 **PAIN AS BAD AS IT COULD BE**

3. Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
NECK	☐ 0	☐ 1	☐ 2	☐ 3	BACK	☐ 0	☐ 1	☐ 2	☐ 3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ☐ 0 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 **VERY POORLY**

When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ Yes ☐ No
If "Yes", please indicate the number of minutes _____ or hours _____ until you are as limber as you will be for the day

How do you feel TODAY compared to ONE WEEK AGO? Please check only one

Much better ☐ Better ☐ the Same ☐ Worse ☐ Much Worse ☐

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

Fatigue is no problem ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Fatigue is a major problem**

FOR Office Use Only: I have reviewed the questionnaire responses.

Date:	**Signature:**

Please list all major illnesses or hospital admissions (other than for operations):		
Year	Reason	Hospital
Please list all operations that you have ever had:		
Year	Reason	Hospital

Please check mark if you have had any of the conditions listed below:		
Head/Eye/Ear/Nose/Throat	**Gastrointestinal**	**Musculoskeletal**
☐ Dry eyes	☐ Stomach ulcer	☐ Back or spine problems
☐ Cataracts	☐ Other gastrointestinal problem	☐ Osteoarthritis
☐ Dry mouth	**Genitourinary**	☐ Rheumatoid arthritis
Cardiovascular	☐ Kidney problem	☐ Lupus
☐ High blood pressure	☐ Gynecological (female) problem	☐ Fibromyalgia
☐ Heart attack	☐ Prostate (male) problem	☐ Broken bones after age 50
☐ Palpitations	**Endocrine**	☐ Osteoporosis
☐ Other heart disease	☐ Diabetes	**Skin**
Respiratory	☐ Thyroid disorder	☐ Psoriasis
☐ Asthma	**Hematologic**	☐ Other skin disease
☐ Severe allergies	☐ Problems with blood clotting	**Psychiatric**
☐ Emphysema	☐ Cancer	☐ Depression
☐ Bronchitis	**Neurologic**	☐ Alcoholism
☐ history of tuberculosis	☐ Stroke	☐ Mental illness
☐ Other respiratory disease	☐ Parkinson's disease	**Other:**

MEDICATION HISTORY

LIST YOUR PRESCRIBED DRUGS

Name the Drug	Strength	Frequency Taken

OVER THE COUNTER MEDICATIONS		
Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

SOCIAL HISTORY

HABITS:

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No

Occupation	What is your current occupation? If retired, what was your past occupation?				
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Have you ever had a fracture (broken bone)?			☐ Yes	☐ No
Females Only	Have you gone thru menopause? If YES, at what age? _____			☐ Yes	☐ No
Bone Density	Have you had a bone density test done? If YES, when and where was this done? _____			☐ Yes	☐ No

PATIENT/GUARDIAN STATEMENT:

To the best of my knowledge, the above information
Is accurate and complete

_____ / /
Patient Signature Date

_____ / /
Guardian Signature Date

_____
Guardian/Authorized Representative Printed Name

PROVIDER STATEMENT:

I have reviewed the questionnaire with the patient

Any Changes

☐ Yes ☐ No _____ / /
Signed Date

☐ Yes ☐ No _____ / /
Signed Date

☐ Yes ☐ No _____ / /
Signed Date

☐ Yes ☐ No _____ / /
Signed Date

☐ Yes ☐ No _____ / /