Baptist
Physician Network
Affiliated with Baptist Hospitals of Southeast Texas
Performing Sacred Work Everyday

Patient History Form

Date of first appointment: ____ / ____ / ____ (Month / Day / Year) Birthplace: _____

Name: _____ (last / first / middle initial / maiden) Birthdate: ____ / ____ / ____ (Month / Day / Year)

Address: _____ (Street / apt#) Age _____ Sex: F ❑ M ❑

_____ (City / State / Zip) Telephone: Home: (____) _____
Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

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)*:

_____

_____

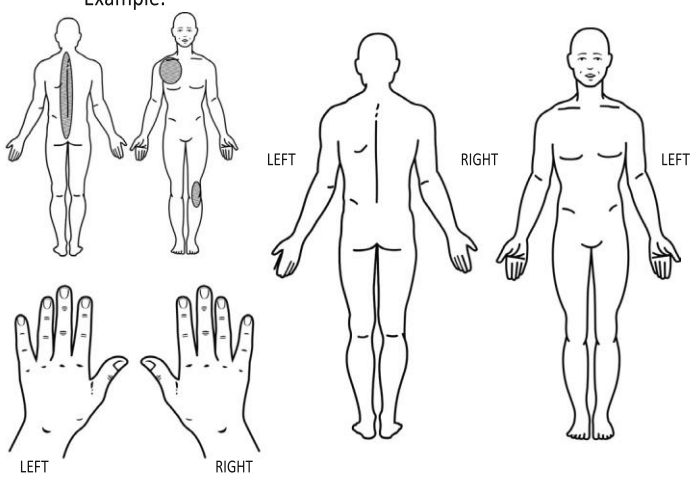
_____

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 (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(Check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	
	Scleroderma			Psoriasis/ Psoriatic Arthritis	
	Vasculitis			Polymyositis/ Dermatomyositis	
	Fibromyalgia			Sjogren's Syndrome	
				Raynauds	

Other arthritis conditions: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No

If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Are you receiving disability? ❑ Yes ❑ No

Are you applying for disability? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

❑ Cancer
❑ Thyroid
❑ Cataracts
❑ Depression
❑ Bad headaches
❑ Kidney disease/ Stones
❑ Anemia
❑ Emphysema
❑ Heart problems
❑ Leukemia
❑ Diabetes
❑ Stomach ulcers
❑ Hepatitis/ Liver Disease
❑ Pneumonia
❑ High Cholesterol
❑ Blood Clots
❑ Asthma
❑ Stroke
❑ Epilepsy
❑ Rheumatic fever
❑ Crohn's/ Ulcerative Colitis
❑ Psoriasis
❑HighBlood Pressure
❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ___/___/___ Date of last eye exam: ___/___/___ Date of last chest x-ray: ___/___/___

Date of last Tuberculosis Test ___/___/___ Date of last bone densitometry ___/___/___

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ q No

How many days apart? _____

Date of last period? ___/___/___

Date of last pap? ___/___/___

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness

Lasting how long?

_____Minutes _____Hours

- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in The cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes *Describe:*_____

Any other serious injuries? ❑ No ❑ Yes *Describe:*_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				

Number of siblings_____ Number living_____ Number decreased_____

Number of children_____ Number living_____ Number decreased_____ List ages of each_____

Health of children_____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list**:**_____

Type of 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	*Helped?* A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Arthrotec/ Diclofenac + misoprostil Celebrex/ Celecoxib Sulindac/ Clinoril Oxaprozin/ Daypro Diflunisal/ Dolobid Piroxicam/ Feldene Indomethacin /Indocin Etodolac /Lodine Ibuprofen/ Mortin/ Advil Relafen/ Nabumetone Naproxen/ Aleve/ Naprosyn Ketoprofen/ Orvdis Tolmetin/ Tolectin Meloxicam/ Mobic Diclofenac/ Voltaren					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Hydrocodone/ Vicodin/ Norco		❑	❑	❑	
Ultram/ Tramadol		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab/ Cimzia		❑	❑	❑	
Golimumab/ Simponi		❑	❑	❑	
Hydroxychloroquine/ Plaquenil		❑	❑	❑	
Leflunomide/ Arava		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine/ Imuran		❑	❑	❑	
Sulfasalazine/ Azulfidine		❑	❑	❑	
Abatacept/ Orencia		❑	❑	❑	
Cyclophosphamide/ Cytoxan		❑	❑	❑	
Cyclosporine A/ Neoral		❑	❑	❑	
Etanercept/ Enbrel		❑	❑	❑	
Infliximab/ Remicade		❑	❑	❑	
Tocilizumab/ Actemra		❑	❑	❑	
Sarilumab/ Kevzara		❑	❑	❑	
Adalimumab/ Humira		❑	❑	❑	
Mycophenolate Mofetil/ Cellcept		❑	❑	❑	
Belimumab/ Benlysta		❑	❑	❑	
Rituximab/ Rituxan		❑	❑	❑	
Secukinumab/ Cosentyx		❑	❑	❑	
Ixekizumab/ Taltz		❑	❑	❑	
Vedolizumab/ Entyvio		❑	❑	❑	
Ustekinumab/ Stelara		❑	❑	❑	
Tofacitinib/ Zeljanz		❑	❑	❑	
Baricitinib/ Olumiant		❑	❑	❑	
Apremilast/ Otezla		❑	❑	❑	
Other:		❑	❑	❑	

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate/ Fosamax		❑	❑	❑	
Ibandronate/ Boniva		❑	❑	❑	
Raloxifene/ Evista		❑	❑	❑	
Zoledronic acid/ Reclast		❑	❑	❑	
Denosumab/ Prolia		❑	❑	❑	
Risedronate/ Actonel/ Atelvia		❑	❑	❑	
Teriparatide/ Forteo		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid/ Benemid		❑	❑	❑	
Colchicine/ Colcyrs		❑	❑	❑	
Allopurinol/ Zyloprim		❑	❑	❑	
Febuxostat/ Uloric		❑	❑	❑	
Pegloticase/ Kyrstexxa		❑	❑	❑	
Lesinurad/ Zurampic		❑	❑	❑	
Others					
Cortisone/ Prednisone		❑	❑	❑	
Viscosupplement Injections/ Supartz/ Synvisc/ Hyalgan/ Euflexxa		❑	❑	❑	
Fibromyalgia Medications					
Duloxetine/ Cymbalta		❑	❑	❑	
Pregabalin/ Lyrica		❑	❑	❑	
Milnacipran/ Savella		❑	❑	❑	
Cyclobenzaprine/ Flexeril		❑	❑	❑	
Amitriptyline/ Elavil		❑	❑	❑	
Fluoxetine/ Prozac		❑	❑	❑	

Please list supplements: _____

_____

Have you had a pneumonia shot? ❑ Yes ❑ No If so, list date _____

Have you had a flu shot? ❑ Yes ❑ No If so, list date _____

Have you had a shingles shot? ❑ Yes ❑ No If so, list date _____

Patient's Name: _____Date:_____Physician Initial: _____

