The Toledo Clinic | Arthritis Associates of Northwest Ohio, Inc.

Name _____ Age _____ Birthdate _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Occupation _____ Average hours worked daily _____ weekly _____

Education : ☐ Grade School ☐ High School ☐ College ☐ Graduate School

Race:
☐ American Indian or Alaska Native
☐ Black or African American
☐ Other Pacific Islander
☐ Asian
☐ White
☐ Hispanic
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race
☐ Unreported/Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Language:
☐ Arabic
☐ Spanish/Castilian
☐ Chinese
☐ No Linguistic Content
☐ English
☐ Not Applicable
☐ French
☐ Korean
☐ Somali

Please list your reasons for seeing the doctor at this time: _____

Date symptoms began: _____

Do you have or have you every had: *(check if yes)*

☐ Swollen joints
☐ Red, warm joint
☐ Bursitis
☐ Tendonitis
☐ Kidney stones
☐ Slipped disk
☐ Psoriasis
☐ Crohns disease
☐ Iritis/Uveitis
☐ Urethritis/PID
☐ Ulcerative colitis
☐ Conjunctivitis (pinkeye)
☐ Problems with dry eyes
☐ Problems with dry mouth
☐ Sores in mouth
☐ Genital sores
☐ Pleurisy
☐ Pericarditis
☐ Tennis elbow
☐ Pinched nerve
(specify) _____
☐ Carpal tunnel syndrome
☐ Rheumatic fever
☐ Anemia
☐ Low white blood count
☐ Low platelet count
☐ Venereal disease
☐ Kidney disease
☐ Ulcers
☐ Hepatitis
☐ Thyroid ☐ *Underactive* ☐ *Overactive*

Check the following surgeries you have had: *(check if yes)*

☐ Hip replacement
☐ Knee replacement
☐ Arthroscopy
☐ Torn cartilage
☐ Hand
☐ Foot/Bunion
☐ Other *(specify)* _____
☐ Neck
☐ Back
☐ Appendectomy
☐ Hysterectomy
☐ Hernia
☐ Gall bladder
☐ Tonsils/Adenoids
☐ Breasts
☐ Carpel Tunnel
☐ Eye/Cataracts
☐ Cystoscopy
☐ Stomach
☐ D&C

Have you had any of the following : *(check if yes)*

☐ Heart attacks/Angina
☐ Heart disease, murmur, heart failure
☐ High blood pressure
☐ Diabetes
☐ Stroke
☐ Migraines
☐ Prostate trouble/cancer
☐ Pneumonia
☐ Fractures *(specify)* _____
☐ Cancer
☐ Emphysema
☐ Tuberculosis
☐ Kidney disease
☐ Liver disease/Cirrhosis
☐ Irritible Bowel Syndrome
☐ Gall Stones
☐ Frequent Sinus Infections
☐ Seizures/Convulsions
☐ Bleeding tendencies
☐ Glaucoma/Eye disease
☐ Asthma/Hay fever
☐ Anxiety
☐ Depression
☐ Phlebitis (blood clot)
☐ Elevated cholesterol/lipids

Drug Allergies? ☐ No ☐ Yes To What _____

List current medications and doses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Have you ever taken: *(check if yes)*

- ☐ Motrin/Ibuprofen
- ☐ Indocin
- ☐ Zyloprim/Allopurinol
- ☐ Fosamax/Alendronate
- ☐ Actonel
- ☐ Mobic
- ☐ Arava
- ☐ Kineret
- ☐ Cyclosporin
- ☐ Reclast
- ☐ Prolia
- ☐ Forteo
- ☐ Humira
- ☐ Xeljanz
- ☐ Uloric
- ☐ Clinoril
- ☐ Naprosyn
- ☐ Feldene
- ☐ Colchicine
- ☐ Voltaren
- ☐ Daypro
- ☐ Evista
- ☐ Cellcept/Mycophenolate
- ☐ Remicade
- ☐ Orencia
- ☐ Actemra
- ☐ Benlysta
- ☐ Stelara
- ☐ Prednisone/Cortisone/Medrol by mouth
- ☐ Cortisone Injections
- ☐ Lodine
- ☐ Relafen
- ☐ Estrogen
- ☐ Celebrex
- ☐ Tymlos
- ☐ Plaquenil/Hydroxychloroquine
- ☐ Azulfidine/Sulfasalazine
- ☐ Methotrexate (Rheumatrex)
- ☐ Imuran
- ☐ Cytoxan
- ☐ Zurampic
- ☐ Simponi Aria

HABITS:

- ☐ I do not smoke
- ☐ I smoke now. How much? _____ How many years? _____
- ☐ I used to smoke. Year quit: _____
- ☐ I do not drink alcoholic beverages.
- ☐ I drink alcohol. ☐ Beer _____ /day ☐ Cocktails _____ /day
- ☐ I use Marijuana
- ☐ I drink milk. _____ glasses/day
- ☐ I drink coffee. _____ cups/daily
- ☐ Do you get enough sleep at night? ☐ Yes ☐ No
- ☐ Do you wake up feeling rested? ☐ Yes ☐ No

FAMILY HISTORY:

	☐ Living Age	Health	☐ Deceased Age at death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children _____ Number Living _____ Number Deceased _____

Last ages of each child _____

Serious illnesses of children _____

_____

Do you know of any ***blood*** relative who has or had *(check and give relationship):*

Yourself	Relative Relationship	Yourself	Relative Relationship
☐ High blood pressure	_____	☐ Heart disease	_____
☐ Diabetes	_____	☐ Stroke	_____
☐ Bleeding tendancies	_____	☐ Alcoholism	_____
☐ Colitis	_____	☐ Asthma	_____
☐ Rheumatic fever	_____	☐ Leukemia	_____
☐ Goiter	_____	☐ Tuberculosis	_____
☐ Epilepsy	_____	☐ Cancer	_____
☐ Arthritis (type unknown)	_____	☐ Ankylosing Spondylitis	_____
☐ Osteoarthritis	_____	☐ Osteoporosis	_____
☐ Rheumatoid Arthritis	_____	☐ Gout	_____
☐ Childhood Arthritis	_____	☐ Lupus	_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

GENERAL:

- ☐ Recent weight gain (Amount _____)
- ☐ Recent loss of weight (Amount _____)
- ☐ Fatigue or weakness
- ☐ Poor appetite
- ☐ Fever or chills
- ☐ Nap during the day
- ☐ Night sweats

SKIN:

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold or when upset
- ☐ Rash on palms/soles
- ☐ Sores/ulcerations on finger tips

EYES:

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Feels like something in eye
- ☐ Seeing flashing lights

NECK:

- ☐ Jaw pain with chewing
- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS:

- ☐ Pain in chest
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Frequent cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Date of last chest x-ray: _____

STOMACH AND INTESTINES:

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stool
- ☐ Frequent or constant heartburn

NOSE:

- ☐ Nosebleeds
- ☐ Loss of smell

SYSTEMS REVIEW (continued)

MOUTH:

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste

THROAT:

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

NERVOUS SYSTEM:

- ☐ Headaches
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Arms or legs tingle/numb
- ☐ Tenderness of the scalp
- ☐ Hearing Loss

KIDNEY/URINE/BLADDER:

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal sores
- ☐ Vaginal dryness
- ☐ Rash on the penis

MUSCLES/JOINTS/BONES:

- ☐ Morning stiffness
- ☐ Lasting how long: _____ Min_____ Hours
- ☐ Joint pain
- ☐ Muscle weakness or pain
- ☐ Stiffness of lower back

List joints affected in the last 6 months:

_____

_____

_____

MENSTRUAL:

Date of last period _____/_____/_____

Date of menopause _____/_____/_____

Date of last pap test _____/_____/_____

Have you ever had a miscarriage? ☐ Yes ☐ No

HAVE YOU EVER HAD?

TB Test: ☐ *No* ☐ *Yes* Date: _____ ☐ *Negative* ☐ *Positive* - Treatment: _____

HIV AIDS Test: ☐ *No* ☐ *Yes* Date: _____ ☐ *Negative* ☐ *Positive* - Treatment: _____

Hepatitis B Test: ☐ *No* ☐ *Yes* Date: _____ ☐ *Negative* ☐ *Positive* - Treatment: _____

Hepatitis C Test: ☐ *No* ☐ *Yes* Date: _____ ☐ *Negative* ☐ *Positive* - Treatment: _____

DO NOT WRITE BELOW THIS LINE