Department of Rheumatology Dr. Andrew Sohn

PATIENT HEALTH HISTORY Date: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

Tonsillectomy_____ Vasectomy_____ Cataracts_____ Prostate Surgery_____
Appendectomy_____ Hysterectomy_____ Gall Bladder_____ Hip Replacement_____
Cardiac By Pass_____ Tubal Ligation_____ Hernia _____ Knee Replacement_____
Cesarean Section_____

OTHER SURGERIES (kind of operation): _____

_____

HOSPITALIZATION HISTORY (Other than for surgery): _____

_____

PAST ILLNESSES (Circle any illnesses you have or have had):

Diabetes	Hearing Loss	Rheumatic Fever	Thyroid Disease
Hay Fever	Anemia	Urine Infections	Bleeding Problems
Asthma	Kidney disease/stones	Head Trauma	Bronchitis/Emphysema
Stroke	Tuberculosis	High Cholesterol	Blood clots in lungs
Seizures	High blood pressure	Irritable bowel syndrome	Irregular heart rhythm
Cataracts	Angina/chest pain	Sexually transmitted disease	Skin conditions
Glaucoma	Heart disease	Hepatitis/Jaundice	
Other: _____		Cancer: _____	

FAMILY HISTORY – Using the above health conditions, please fill in the following:

Relative	Age	List Any Diseases	If Deceased, Cause of Death
Father			
Mother			
Father's Parent's (M)			
(F)			
Mother's Parent's (M)			
(F)			
Brother (B) or ( )			
Sister (S) ( )			
( )			
( )			
( )			
Children: Son (S)			
Daughter (D)			
( )			
( )			

ALLERGIES: Offending Drugs or Foods (including aspirin, iodine, latex, etc.)

_____ Reaction _____ _____ Reaction _____

_____ Reaction _____ _____ Reaction _____

_____ Reaction _____ _____ Reaction _____

SYSTEMS REVIEW Indicate for how long (for example, number of days, months or years) Circle if yes and for how long.

ALLERGY
Hay fever No Yes

GENERAL
Poor appetite No Yes
Fever No Yes
Chills No Yes
Fatigue No Yes
Sleep poorly No Yes
Dizziness No Yes
Enlarged glands No Yes
Weight change No Yes

EYES
Eye problem No Yes

ENT
Sinusitis No Yes
Deafness No Yes
Ear pain No Yes

CARDIOVASCULAR
Chest pain No Yes
Fast heart No Yes
Irregular heartbeat No Yes
Swelling of feet, hands, face No Yes

RESPIRATORY
Shortness of breath No Yes
Cough No Yes
Coughing blood No Yes
Asthma No Yes

GASTROINTESTINAL
Nausea No Yes
Vomiting No Yes
Heart burn No Yes
Trouble swallowing No Yes
Abdominal pain No Yes
Blood in stools No Yes
Hemorrhoids No Yes
Constipation No Yes
Bloating No Yes
Diarrhea No Yes
Liver or gall bladder disease No Yes
Black stools No Yes

DERMATOLOGY
Rash No Yes

MUSCULOSKELETAL
Back pain No Yes
Joint pain No Yes
Stiff neck No Yes
Muscle weakness No Yes

NEUROLOGICAL
Headaches No Yes
Paralysis No Yes
Numbness No Yes
Fainting No Yes

PSYCHIATRIC
Depression No Yes
Anxiety No Yes

ENDOCRINE
Warmer then others No Yes
Colder than others No Yes

GENITOURINARY Yes
Albumin or protein urine No Yes
Sugar in urine No Yes
Blood in urine No Yes
Urinary frequency No Yes
Pain in urination No Yes
Empty bladder at night No Yes

IF FEMALE:
Menstruate _____ Yes _____ No
Every _____ days, for ____ days each period.
_____ Pads per day. Last period _____

REMARKS:_____
_____
_____

Please list any medicines (prescription or over-the-counter) or vitamins you take on a regular basis.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL HISTORY

Marital Status: (circle) Single Married Divorced Widowed

Name of persons living in your household:

Name/Relationship to you	Name/Relationship to you
_____	_____
_____	_____
_____	_____

Occupation: _____

Hobbies: _____

Exercise: Frequency _____ Type of exercise _____

Alcohol: Regular Basis _____ Type/quantity _____

Quit Date _____ Past use quantity _____

Tobacco: Packs per day _____ How may years _____ Quit Date _____

Use smokeless _____ Cigars _____

WOMEN ONLY: Number of pregnancies_____ Deliveries _____

Miscarriages/abortions _____ Living Children _____

DATE OF YOUR MOST RECENT:	DATE OF YOUR LAST VACCINE:
Cholesterol Level _____	Influenza _____
Eye Examination _____	Pneumonia _____
Mammogram _____	
TB Test _____	

Have you ever had a blood transfusion?_____ Year of Transfusion _____

_____

_____

_____

Date Review	By	Date Review	By	Date Review	By
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____