HIGHLAND CLINIC

FAX FORM TO 4451

DATE:_____ PATIENT HISTORY FORM PCP / REFERRING MD

MD Seeing Today: ☐ Kampert RHEUMATOLOGY _____

☐ Walton

Name:_____DOB:_____Age:_____

Reason for Visit:_____

Medical History:

Have you ever had?

☐ None
☐ Heart Disease
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease
☐ Cancer
☐ Blood Clot
☐ Diabetes
☐ Hypertension
☐ Stroke
☐ Seizure
☐ Neuropathy
☐ Depression
☐ Hallucination
☐ Anemia
☐ Platelet disorder
☐ Blood transfusion
☐ Miscarriage
☐ Other_____

☐ Rheumatoid Arthritis
☐ Lupus
☐ Osteoporosis
☐ Osteoarthritis
☐ Gout
☐ Sjorgren's
☐ Raynaud's
☐ Scleroderma
☐ Fibromyalgia
☐ Psoriasis
☐ Sarcoidosis
☐ Stomach/Intestine Blood
☐ Celiac Disease
☐ Crohn's/Ulcerative Colitis
☐ Lyme Disease
☐ Ankylosing Spondylitis
☐ Glaucoma
☐ Tuberculosis
☐ Sexually Transmitted Disease

Surgical History:

☐ Appendectomy
☐ Hysterectomy
☐ Bone or Joint
☐ Wisdom Teeth
☐ Gallbladder
☐ Heart Bypass
☐ Colonoscopy
☐ Cosmetic Surgery
☐ Organ Transplant
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____

Social History:

Occupation:_____
Disability: Yes No
Use or Ever Use?
Tobacco: Yes No Quit
Type_____
How much_____
How long_____
Alcohol: Yes No Quit
Type_____
How much_____
How long_____
Illicit Drugs: Yes No Quit
Type_____
How much_____
How long_____
☐ Tattoos: Yes No
Date of most recent_____
☐ Body Piercing Yes No
Date of most recent_____

Review of Systems: Do you have?

☐ Fatigue
☐ Fever
☐ Chills
☐ Weight Gain
☐ Weight Loss
☐ Night Sweats
☐ Headaches
☐ Depression
☐ Skin Rash

☐ Vision Changes
☐ Dry gritty eyes
☐ Dry Mouth
☐ Swollen Facial Glands
☐ Difficulty swallowing
☐ Hoarseness
☐ Chest Pain
☐ Anxiety
☐ Tight Skin

☐ Irregular Heartbeat
☐ Shortness of Breath
☐ Cough
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Watery Stool
☐ Memory Loss
☐ Mouth or nose ulcer

☐ Blood in Stool
☐ Black Tarry Stool
☐ Abdominal Pain
☐ Blood in urine
☐ Painful urination
☐ Numbness or tingling
☐ Extremity swelling
☐ Hallucinations
☐ Genital ulcer or discharge
☐ LMP(females)_____

☐ Do you sunburn more easily than you used to?
☐ Do your fingers turn colors when holding a cold glass?

☐ Muscle pain ☐ Muscle Weakness

Resulting limitations?_____

☐ Painful joints ☐ Swollen joints

Which ones?_____

For how long?_____

Patient Name:_____ Date:_____

ALLERGIES:

☐ NONE
☐ Medications
Medication_____Reaction_____Age at the Time_____
Medication_____Reaction_____Age at the Time_____
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Medication_____Reaction_____Age at the Time_____
Medication_____Reaction_____Age at the Time_____
Medication_____Reaction_____Age at the Time_____
☐ Latex

Current Medications: *(prescription, over-the-counter, herb or supplement)*
Drug Name Dose/Strength How you take it (for example, 1 a day, 2 a day, etc)
☐ NONE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History: *Please indicate family member*
Father: Living/ Deceased Age:____ Health Problems:_____
Mother: Living/Deceased Age:____ Health Problems:_____
Brother: Living/ Deceased Age:____ Health Problems:_____
Brother: Living/Deceased Age:____ Health Problems:_____
Brother: Living/ Deceased Age:____ Health Problems:_____
Sister: Living/Deceased Age:____ Health Problems:_____
Sister: Living/ Deceased Age:____ Health Problems:_____
Sister: Living/Deceased Age:____ Health Problems:_____
Child: Living/ Deceased Age:____ Health Problems:_____
Child: Living/Deceased Age:____ Health Problems:_____
Child: Living/ Deceased Age:____ Health Problems:_____
Child: Living/Deceased Age:____ Health Problems:_____
Any family members known with reasonable certainty to have any of the following?
☐ Osteoarthritis ☐ Gout ☐ Psoriasis ☐ Thyroid Disease ☐ Rheumatoid Arthritis
☐ Lupus ☐ Crohn's Disease ☐ Diabetes ☐ Osteoporosis ☐ Scleroderma
☐ Ulcerative Colitis ☐ Fibromyalgia ☐ Sarcoidosis ☐ Celiac Disease ☐ Sjogren's
☐ Ankylosing Spondylitits