PREMIER *medical group*

INSTRUCTIONS

- Complete the *Health History Questionnaire*.

Bring all completed paperwork to your scheduled appointment along with:

- Medical insurance and prescription cards.
- Picture ID
- Any recent labs and radiology reports from the past 1-2 years.
- List of medications and allergies.

What can I expect at my appointment?

- Dr. Khan will take your history and you will have a complete physical exam.
- Please bring/wear a pair of sweats/loose pants and a t-shirt to change into, or we can provide you with a paper gown.
- Please allow 2 hours for your appointment.

NO SHOW POLICY

A fee may be charged to any patient who does not cancel their office visit within 48 hours and will be charged for any no show for an office procedure.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.

PREMIER *medical group*

RHEUMATOLOGY PATIENT HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____ **BIRTHPLACE:** _____

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ PARTNER / SIGNIFICANT OTHER
☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

REFERRED BY:

☐ SELF ☐ DOCTOR NAME: _____ OTHER HEALTHCARE PROVIDER: _____

DESCRIBE BRIEFLY YOUR PRESENT SYMPTOMS: _____

_____

_____

WHEN DID YOUR SYMPTOMS START? (MONTH, DAY, YEAR)? _____

WHAT DIAGNOSIS HAVE YOU BEEN GIVEN, IF ANY? _____

_____

PLEASE LIST THE NAMES OF OTHER PRACTITIONERS YOU HAVE SEEN FOR THIS PROBLEM:

_____

_____

PAST MEDICAL & SURGICAL HISTORY

PLEASE LIST ANY MEDICAL PROBLEMS YOU HAVE OR HAD IN THE PAST:

_____

_____

_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD, YEAR, HOSPITAL, AND REASON FOR SURGERY:

_____

_____

INITIALS: _____

ANY PREVIOUS FRACTURES? ☐ NO ☐ YES - PLEASE DESCRIBE: _____

_____

ANY OTHER SERIOUS INJURIES? ☐ NO ☐ YES - PLEASE DESCRIBE: _____

_____

MEDICATIONS & ALLERGIES

PLEASE LIST ALL CURRENT MEDICATIONS, DOSE AND HOW OFTEN YOU ARE TAKING THEM:

_____

_____

_____

_____

_____

PLEASE LIST ANY DRUG ALLERGIES YOU HAVE: NAME OF MEDICATION AND THE REACTION:

_____

_____

INFECTION, TRAVEL & IMMUNIZATION HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF YES, PLEASE LIST DATE:

☐ TUBERCULOSIS: _____ ☐ HEPATITIS B: _____ ☐ HEPATITIS C: _____

☐ HIV: _____ ☐ LYME: _____ ☐ COVID: _____

☐ SHINGLES: _____ ☐ OTHER: _____

HAVE YOU EVER TRAVELLED TO ANY OTHER COUNTRIES OUTSIDE OF USA AND CANADA?

☐ NO ☐ YES, PLEASE LIST: _____

HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS? IF YES, PLEASE LIST DATES (MONTH/YEAR):

☐ INFLUENZA: _____ ☐ SHINGREX (SHINGLES VACCINE): _____

☐ COVID: _____ ☐ COVID BOOSTER: _____

☐ PNEUMOVAX (PNEUMONIA VACCINE): _____

INITIALS: _____

FAMILY HISTORY

DOES ANY FAMILY MEMBER RELATED TO YOU BY BLOOD HAVE ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE LIST RELATIVE/RELATIONSHIP (I.E. MATERNAL/PATERNAL):

- ☐ RHEUMATOID ARTHRITIS: _____
- ☐ LUPUS OR SLE: _____
- ☐ ANKYLOSING SPONDYLITIS: _____
- ☐ PSORIATIC ARTHRITIS: _____
- ☐ PSORIASIS: _____
- ☐ ARTHRITIS: _____
- ☐ GOUT: _____
- ☐ OSTEOARTHRITIS: _____

DOES ANY FAMILY MEMBER RELATED TO YOU BY BLOOD HAVE THE FOLLOWING AND/OR OTHER ILLNESS? IF YES, PLEASE LIST RELATIVE/RELATIONSHIP.

- ☐ CANCER: _____
- ☐ LEUKEMIA OR LYMPHOMA: _____
- ☐ COLITIS: _____
- ☐ HEMOCHROMATOSIS: _____
- ☐ CELIAC DISEASE: _____
- ☐ DIABETES: _____
- ☐ MULTIPLE SCLEROSIS: _____
- ☐ HEART DISEASE: _____
- ☐ HYPERTENSION: _____
- ☐ STROKE: _____

	IF LIVING		**IF DECEASED**	
	AGE	**HEALTH**	**AGE AT DEATH**	**CAUSE**
FATHER				
MOTHER				

NUMBER OF SIBLINGS: _____ **NUMBER LIVING:** _____

NUMBER OF CHILDREN: _____ **NUMBER LIVING:** _____

LIST AGES OF EACH CHILD IF APPLICABLE: _____

HEALTH OF CHILDREN: _____

INITIALS: _____

PERSONAL HISTORY

WHAT IS YOUR HIGHEST EDUCATION LEVEL?

☐ HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE GRADUATE

☐ ADVANCED DEGREE ☐ OTHER: _____

WHAT IS YOUR CURRENT OR PAST OCCUPATION?

_____

ARE YOU CURRENTLY WORKING?

☐ EMPLOYED AS: _____ ☐ SELF-EMPLOYED AS: _____

☐ HOME MAKER ☐ RETIRED ☐ STUDENT

☐ MEDICAL LEAVE ☐ LOOKING FOR WORK ☐ DISABILITY

☐ OTHER: _____

WITH WHOM DO YOU CURRENTLY LIVE? PLEASE LIST RELATIONSHIP AND AGE OF EACH PERSON:

_____

_____

DO YOU HAVE ANY PETS?

☐ YES, PLEASE LIST:_____ ☐ NO

DO YOU SMOKE OR VAPE?

☐ NO

☐ YES - STARTED AGE: _____ HOW MANY CIGARETTES/DAY: _____

☐ FORMER SMOKER OR VAPING – FROM AGE: _____ TO AGE: _____ HOW MANY CIGARETTES/DAY: _____

DO YOU DRINK ALCOHOL?

☐ NO ☐ YES – USUAL DRINK: _____ HOW MUCH: _____

HAS ANYONE EVER TOLD YOU TO CUT BACK ON YOUR DRINKING?

☐ YES ☐ NO

INITIALS: _____

DO YOU USE RECREATIONAL DRUGS?

☐ NO ☐ YES - PLEASE LIST:_____

ARE YOU APPLYING FOR OR RECEIVING DISABLITY?

☐ NO ☐ YES, APPLYING FOR DISABILITY ☐ YES, RECEIVING DISABILITY

DO YOU HAVE ANY MEDICALLY RELATED LAWSUIT PENDING?

☐ YES ☐ NO

PATIENT GLOBAL ASSESSMENT OF DISEASE ACTIVITY: CONSIDERING ALL THE WAYS YOR ARTHRITIS OR CONDITION AFFECTS YOU, RATE HOW WELL YOU ARE DOING ON THE FOLLOWING SCALE:

	0	1	2	3	4	5	6	7	8	9	10	
Very well	○	○	○	○	○	○	○	○	○	○	○	Very poor

WE ARE INTERESTED IN LEARNING HOW YOUR ILLNESS AFFECTS YOUR ABILITY TO FUNCTION IN DAILY LIFE. PLACE AN "X "IN THE BOX WHICH BEST DESCRIBES YOUR USUAL ABILITIES <u>OVER THE PAST WEEK</u>. ARE YOU ABLE TO:

TOTAL SCORE: _____ **TOTAL SCORE/10: _____**	**WITHOUT ANY DIFFICULTY (0)**	**WITH SOME DIFFICULTY (1)**	**WITH MUCH DIFFICULTY (2)**	**UNABLE (3)**
GET ON AND OFF THE TOILET?	☐	☐	☐	☐
OPEN CAR DOORS?	☐	☐	☐	☐
STAND UP FROM A STRAIGHT CHAIR?	☐	☐	☐	☐
WALK OUTDOORS ON FLAT GROUND?	☐	☐	☐	☐
WAIT IN LINE FOR 15 MINUTES?	☐	☐	☐	☐
REACH AND GET DOWN A 5-POUND OBJECT (EX. BAG OF SUGAR) FROM JUST ABOVE YOUR HEAD?	☐	☐	☐	☐
GO UP 2 OR MORE FLIGHTS OF STAIRS?	☐	☐	☐	☐
DO OUTSIDE WORK (SUCH AS YARD WORK)?	☐	☐	☐	☐
LIFT HEAVY OBJECTS?	☐	☐	☐	☐
MOVE HEAVY OBJECTS?	☐	☐	☐	☐

INITIALS: _____

SYSTEMS REVIEW

Date of last eye exam: _____ Date of last chest x-ray: _____

Date of last bone density test: _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

GENERAL

- ☐ Recent weight gain; how much _____
- ☐ Recent weight loss; how much _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES

- ☐ Morning stiffness
  Lasting how long _____ Minutes
  _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months:

_____

_____

_____

_____

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE

- ☐ Nosebleeds
- ☐ Loss of Smell

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK

- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden change in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs of feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

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 dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

BLOOD

- ☐ Anemia
- ☐ Bleeding tendency

SKIN

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC

- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

☐ NO ☐ YES

If yes, what age?_____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ☐ YES ☐ NO

How many days apart? _____

INITIALS: _____