WILLIAM P. MAIER, MD, PC
RHEUMATOLOGY

PERIODICAL HEALTH HISTORY UPDATE

Date ____________________

Patient name ______________________________ Age ________ Date of birth ________

Primary Care Physician (PCP) ______________________ Referred by ____________________

Other physicians involved in my care ______________________________

General health (circle): Excellent Good Fair Poor Recent travel outside U.S.A.? ____________

Occupation(s) ______________________________

Reason for seeking medical attention ______________________________

____

REVIEW OF SYMPTOMS: Check any of the following symptoms you have experienced WITHIN THE PAST YEAR

GENERAL:
- ❑ change in heat & cold tolerance
- ❑ chills or fever
- ❑ daytime sleepiness
- ❑ excess appetite
- ❑ increased thirst
- ❑ lack of appetite
- ❑ night sweats
- ❑ swollen glands
- ❑ unusual fatigue
  - (early a.m.)____
  - (late p.m.)____
- ❑ unusual weakness
- ❑ weight change
  - increase____
  - decrease____

SKIN:
- ❑ bruise easily
- ❑ change in skin or mole
- ❑ change in hair:
  - loss ____________
  - texture ____________
  - increased hair ______
- ❑ dryness of skin ______
- ❑ itching
- ❑ rash or hives
- ❑ nail change

EYES:
- ❑ blind spells (in one eye)
- ❑ blurry vision
- ❑ change in vision
- ❑ contact lenses
- ❑ double vision
- ❑ eye infection
- ❑ eye pain
- ❑ wear glasses

EARS:
- ❑ earache
- ❑ hearing loss
- ❑ infection or drainage
- ❑ ringing in ears
- ❑ use hearing aid

THROAT:
- ❑ bleeding gums
- ❑ frequent sore throat
- ❑ hoarseness
- ❑ neck swelling/lumps
- ❑ sores in mouth

NOSE:
- ❑ Hayfever
- ❑ nose bleeds
- ❑ polyps
- ❑ post nasal drip
- ❑ runny nose/sneezing
- ❑ sinus trouble
- ❑ stuffy

BREASTS:
- ❑ discharge/bleeding
- ❑ lump
- ❑ pain

HEART AND LUNGS:
- ❑ white, blue or purple discoloration of hands or feet
- ❑ calf pain when walking
- ❑ chest discomfort/pain
- ❑ cough up blood
- ❑ cough up phelgm
- ❑ difficulty breathing
- ❑ irregular heart beat
- ❑ persistent cough
- ❑ racing or fluttering heart
- ❑ shortness of breath
- ❑ swollen feet or ankles
- ❑ varicose veins
- ❑ wheezing

GASTROINTESTINAL:
- ❑ belching
- ❑ bloody or black stools
- ❑ change in stools
- ❑ constipation
- ❑ difficult swallowing
- ❑ excessive gas
- ❑ food intolerance
- ❑ heartburn/esophagal reflux
- ❑ hemorrhoids
- ❑ loose bowels/diarrhea
- ❑ nausea
- ❑ recurrent abdominal pain
- ❑ vomiting

URINARY:
- ❑ change urinary stream
- ❑ blood in urine
- ❑ difficulty starting, stopping urinary stream
- ❑ extreme urge to urinate
- ❑ frequency
- ❑ leaking urine
- ❑ pain or burning on urination
- ❑ unusually large volumes of urine
- ❑ up at night to urinate? how often?____________

BONES AND JOINTS:
- ❑ back or neck pain
- ❑ cramps in muscles
- ❑ deformities of joints or extremities
- ❑ foot trouble
- ❑ painful or stiff joints
- ❑ pain down backs of legs
- ❑ reddness of joints

MOOD/MENTAL HEALTH:
- ❑ depressed or sad
- ❑ irritable or angry
- ❑ anxious, tense, or worried
- ❑ fearful
- ❑ sleep problems
- ❑ change in appetite
- ❑ crying easily or often
- ❑ low self esteem
- ❑ loss of interest in activities
- ❑ fatigue
- ❑ suicidal thoughts
- ❑ compulsive behaviors
- ❑ concentration/memory problems
- ❑ marital, family or work problems
- ❑ stress

NEUROLOGIC:
- ❑ coordination problems
- ❑ difficulties in speaking
- ❑ dizziness
- ❑ fainting spells
- ❑ frequent headaches
- ❑ loss of balance
- ❑ loss of sensation
- ❑ memory or thinking problems
- ❑ muscle weakness
- ❑ numbness or tingling
- ❑ tremor
- ❑ trouble walking

OCCUPATIONAL :
- ❑ worrisome exposures

OTHER CONCERNS:
- ❑ ____________________
  ____
  ____

For doctor use only

MEDICINES (include non-presc[illegible]on drugs, herbs & vitamins)

Current medications	Dosage	Current medications	Dosage

HOSPITALIZATIONS, OPERATIONS, INJURIES, AND SERIOUS ILLNESSES AND ACCIDENTS

List since previous physical, if not previously listed. List cause or type. Include psychiatric, but omit pregnancies

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

PREVENTIVE CARE / IMMUNIZATION HISTORY: Please date those you have had with most current date

Diptheria / Tetanus ______ Tetanus ______ Diptheria / Pertussis Tetanus ______ Flu ______ Pneumovax ______ Hepatitis A ____ B ____
Measles ________ Mumps ________ Rubella ________ Chicken Pox ________ Mammogram: ________ TB skin test ________
Pap: ________ Hemocult ________ Sigmoidoscopy ________ Eye exam ________ Other ________

LIFESTYLES: Do you participate in the following?

	Yes	No	If yes, now or ever, describe
Alcohol			
Tobacco			
Illicit drugs			
Coffee / tea / cola			
Regular exercise			

Weight current ________ 1 year ago ________ 5 years ago ________
Any special diet ________
Are there any cultural or personal beliefs that you would like me to know about? If so, please list or mention ________

Are you currently or have you ever been in a relationship where you were hurt, threatened, or made to feel afraid? Yes No

MALE HEALTH HISTORY / GENITO-REPRODUCTIVE

- ❑ History of sexually transmitted disease? ________
- ❑ Discharge from penis? ❑ Testicular pain? ❑ Lumps in testicles or scrotum? ❑ Decrease / increase in testicular size?
- ❑ Decrease / increase in sexual desire? ❑ Decreased ability in achieving erection?

Do you have concerns about your sex life? ________
Any other problems? ________

FEMALE HEALTH HISTORY / GENITO-REPRODUCTIVE

Age of onset of menstrual periods ________
Age when periods stopped (menopause) ________
First day of last period ________
Days between your periods?(start date to next start date) ________
How many days do they last? ________
Is flow: ❑ heavy ❑ scanty ❑ normal?
Do you ever bleed between periods? ________
Menstrual pain? ________
Heavy vaginal discharge? ________

History of sexually transmitted disease? ________
Decrease / increased in sexual desire? ________
Have you had vaginal bleeding since menopause? ❑ yes ❑ no
Hot flashes? ❑ yes ❑ no
Have you had abnormal Paps? ________ Date? ________
Do you have history of:
❑ endometriosis? ❑ ovarian growths?
❑ DES exposure? ❑ infertility? ❑ fibroids?
Current contraception being used? ________

Do you have concerns about your sex life? ________
Any other problems? ________

List pregnancies: number of pregnancies ________ live births ________ miscarriage(s) ________

For doctor's use only Exam done by ________ Date ________
Physician / provider

PERSONAL HISTORY (Please circle and date those YOU have had)

AIDS or HIV positive ______
Anemia ______
Angina-heart pain ______
Arthritis or rheumatism ______
Asthma or hay fever ______
Bladder or prostate trouble ______
Blindness ______
Blood transfusion ______
Bone disease ______
Cancer ______
Cholesterol/ triglyceride problem ______
Chronic bronchitis ______
Colitis or bowel disease ______
Diabetes ______
Diverticulosis ______
Eating disorder ______
Emotional disorder ______
Eye disease or glaucoma ______
Gall bladder disease ______
Gout ______
Heart disease ______
______
Head injury ______

Hepatitis or "Yellow" Jaundice ______
Hernia ______
High blood pressure ______
Kidney disease or stones ______
Liver disease ______
Lung disease ______
Mental illness ______
Migraine headache ______
Paralysis ______
Pneumonia ______
Polio ______
Polyps, colon ______
Phlebitis (clot) ______
Scarlet Fever ______
Seizures/convulsions ______
Skin trouble/disease ______
Stroke ______
Thyroid disease ______
Tonsils removed (age) ______
Transfusion ______
Tuberculosis ______
Ulcers ______
Urinary Tract Infection ______
Other ______

CHILDHOOD ILLNESSES: Please list age(s)

Measles ______ Mumps ______ Rubella ______ Chicken Pox ______
Rheumatic Fever ______ Other ______

For doctor use only

ADULT HEALTH HISTORY

Patient name ______________________________ Date ____________

Gender: ❑ male ❑ female Education (years): High School ___ College ___ Advanced ___

FAMILY HISTORY	IF LIVING		IF DECEASED	
Relation	Age	Health	Age at death	Cause
Father				
Mother				
Brother or sister: (m/f)				
1.				
2.				
3.				
4.				
5.				
6.				
Spouse				
Children (m/f)				
1.				
2.				
3				
4.				
5.				
6.				

Has any blood relative (parents, grandparents, brothers, sisters, aunts, uncles, etc.) ever had:

If yes, indicate relation and age of onset

- Allergy / asthma ____________
- Arthritis / Gout ____________
- Blood disease: bleeding disorder ____________
  - clotting disorder ____________
- Cancer ____________
- Colon polyp ____________
- Depression ____________
- Diabetes ____________
- Epilepsy / seizures ____________
- Glaucoma ____________
- Heart disease / Coronary artery disease ____________
- High blood pressure ____________
- Liver disease ____________
- Kidney disease ____________
- Mental illness ____________
- Alcohol / substance abuse ____________
- Migraine headaches ____________
- Overweight ____________
- High cholesterol ____________
- Stroke ____________
- Thyroid disease ____________

ALLERGIES (include adverse reactions to medicines, foods, materials, etc.)

Allergy	Reaction (examples)

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MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? ______________________________

____

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	Please check: 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/Dosage	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					
Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac)					
Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac)					
Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen)					
Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name ______________________ Date ______________________ Physician Initials ________

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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid (Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiludronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc injections		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	
Please list supplements:					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, list: ______________________________

____

____

____

____

Patient's Name ____________________ Date ____________________ Physician Initials ________

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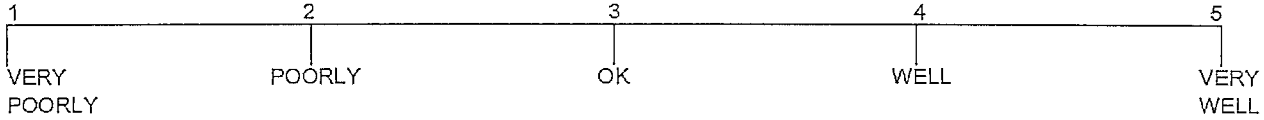
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? ____________

How many people in household? __________ Relationship and age of each ____________

Who does most of the housework? ________ Who does most of the shopping? ________ Who does most of the yard work? ________

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	☐	☐	☐
Walking?	☐	☐	☐
Climbing stairs?	☐	☐	☐
Descending stairs?	☐	☐	☐
Sitting down?	☐	☐	☐
Getting up from chair?	☐	☐	☐
Touching your feet while seated?	☐	☐	☐
Reaching behind your back?	☐	☐	☐
Reaching behind your head?	☐	☐	☐
Dressing yourself?	☐	☐	☐
Going to sleep?	☐	☐	☐
Staying asleep due to pain?	☐	☐	☐
Obtaining restful sleep?	☐	☐	☐
Bathing?	☐	☐	☐
Eating?	☐	☐	☐
Working?	☐	☐	☐
Getting along with family members?	☐	☐	☐
In your sexual relationship?	☐	☐	☐
Engaging in leisure time activities?	☐	☐	☐
With morning stiffness?	☐	☐	☐
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	☐	☐	☐

What is the hardest thing for you to do? ____________________

Are you receiving disability? .... Yes ☐ No ☐

Are you applying for disability? .... Yes ☐ No ☐

Do you have a medically related lawsuit pending? .... Yes ☐ No ☐

Patient's Name ____________ Date ____________ Physician Initials ______

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