Rheumatology
Health History Questionnaire

DuPage Medical Group
WE CARE FOR YOU

Dear Patient:

Welcome to DuPage Medical Group Rheumatology. We need your help to provide you with the best possible care. **Please BRING the following information with you:**

_____ Completed New Patient Packet

_____ Copies of blood tests, x-rays, scans, MRI's done within the last 2 years unless you are an existing DuPage Medical Group patient. You need to bring only the reports, not the actual films.

_____ Please bring all medication that you are currently taking including vitamins.

_____ Please do not ask your primary care doctor to fax or mail this information to us. Faxed copies are often illegible and mailed records often do not reach us by your appointment.

We also request that you bring:

_____ Insurance Cards(s)

_____ Written referral, if applicable. If you are a member of an HMO or POS, it is **YOUR** responsibility to provide us with a referral at the time of service. Be sure to check the dates! Referrals are dated and often expire after a determined time. In most instances, a follow-up appointment will require another referral.

_____ Copayments are due at the time of service. We accept cash, check, MasterCard, Visa, American Express and Discover.

We have scheduled your appointment for:_____

Please arrive at least 15 minutes prior to your appointment time to complete registration.

If you are unable to keep your appointment, please call our office at (630) 268-0200 at least 48 hours (2 business days) prior to your appointment.

Item No. 1241A

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PATIENT'S NAME _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age_____ ☐ Deceased/Age_____ ☐ Major Illnesses_____

EDUCATION (Circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

OCCUPATION:_____ Number of hours worked/average per week _____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care:_____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name:_____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate):_____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later.

_____

_____

_____

_____

_____

Please list the names of other practitioners you have seen for this problem:

_____

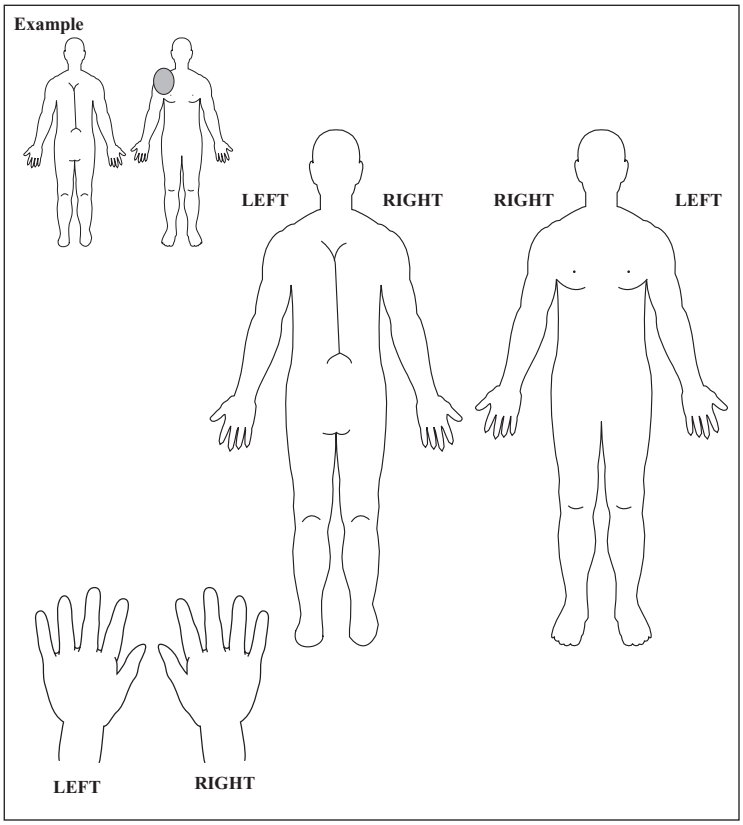
_____

_____

_____

_____

Please shade all the locations of your pain over the past week on the body figures and hands.



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RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical?

☐ Yes ☐ No If yes, please list: _____

_____

Do you exercise regulary? ☐ Yes ☐ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Cancer	☐ Heart Problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epliepsy
☐ Nervous breakdown	☐ Stomach ulcers	☐ Rheumatic fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	*Year*	*Surgeon/City*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fracture? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

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FAMILY HISTORY:

	Age	IF LIVING Health	Age at Death	IF DECEASED Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

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

☐ Cancer_____ ☐ Heart disease _____ ☐ Rheumatic fever_____ ☐ Tuberculosis_____

☐ Leukemia_____ ☐ High blood pressure_____ ☐ Epilepsy_____ ☐ Diabetes_____

☐ Stroke _____ ☐ Bleeding tendency _____ ☐ Asthma _____ ☐ Goiter _____

☐ Colitis _____ ☐ Alcoholism _____ ☐ Psoriasis_____

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.			☐	☐	☐

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

If yes, list:_____

_____

_____

_____

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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 medications, 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)		☐	☐	☐	
Check any you have taken in the past ☐ Ansaid (flurbiprofen) ☐ Vioxx (refecoxib) ☐ Tolectin (tolmetin) ☐ Trilisate (choline magnesium trisalicylate) ☐ Aspirin (including coated aspirin) ☐ Arthrotec (diclofenac + misoprostil) ☐ Voltaren (diclofenac) ☐ Disalcid (salsalate) ☐ Dolobid (diflunisal) ☐ Celebrex (celecoxib) ☐ Daypro (oxaprozin) ☐ Lodine (etodolac) ☐ Meclomen (meclofenamate) ☐ Feldene (piroxicam) ☐ Indocin (indomethacin) ☐ Naprosyn (naproxen) ☐ Oruvail (ketoprofen) ☐ Motrin/Rufen (ibuprofen) ☐ Nalfon (fenoprofen)					
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)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
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:					

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SYSTEMS REVIEW:

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram _____/_____/_____ Date of last eye exam _____/_____/_____ Date of last chest x-ray _____/_____/_____

Date of last tuberculosis test _____/_____/_____ Date of last bone densitometry _____/_____/_____

Constitutional
- ☐ Recent weight gain amount _____
- ☐ Recent weight loss amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

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

Ears – Nose – Mouth – Throat
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

Genitourinary
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For Women Only:

Age when periods began: _____
Periods regular? ☐ Yes ☐ No
How may days apart? _____
Date of last period?_____/_____/_____
Date of last pap?_____/_____/_____
Bleeding after menopause? ☐ Yes ☐ No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal
- ☐ Morning stiffness
  Lasting how long?
  _____ Minutes _____Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 mos.

_____
_____
_____
_____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats

Psychiatric
- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

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HOME CONDITIONS:

Check one: ☐ House ☐ Apartment ☐ Other

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

How many people in household?_____

Relationship	**Age**

Who does most of the	
housework	
shopping	

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

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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

	Usually	**Sometimes**	**No**
Using your heands to grasp small object? (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 a 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

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In order to provide you with the highest standard of quality care and to meet your needs in a timely fashion, please review the following guidelines.

Refills

- **Please be sure to request any prescription refills during your visit.**
- Between visits, the most efficient way to get your prescription refilled is to contact your pharmacy; they will contact our office with all necessary information.
- It may take **48-72** hours for a refill request to be processed.
- Some medications require blood work monitoring and may not be refilled if the monitoring requirements are not met.
- Patients are responsible for submitting prescriptions and paperwork to their mail order pharmacies.
- The office will not refill prescriptions after hours or on weekends.

Referrals

- Referrals may take 3-5 buisness days to process and obtain approval from your insurance company.
- If you are an HMO patient, please be sure you have a current referral for future appointments.
- You can obtain copies of your referrals by calling our Utilization Managment Department at 630-942-7995.

Results

- You will be notified by letter or phone of all test results. If you have not received results in two weeks, please contact our office.

Insurance Questions

If you have insurance, it is your responsibility to know the answers to these questions:

- What is my co-payment amount? If my insurance card does not state a co-payment do I still have one?
- Do I have co-insurance in addition to my co-payment?
- Do I have a deductible? How much is it? Is it person or family?
- Do I need a referral to see another doctor or for any services done outside my primary care physician's office?
- Which hospital is in-network?