PATIENT NAME: ____________________________________ DATE: ____________________________

MEDICATION ALLERGIES: _____________________________

DATE OF LAST COMPLETE PHYSICAL: ___________________ BY WHOM? _______________________

CURRENT MEDICATIONS: PLEASE INCLUDE ANY NON-PRESCRIPTION DRUGS SUCH AS ASPIRIN, TYLENOL, ETC.

NAME OF MEDICATION	STRENGTH (MG)	HOW OFTEN TAKEN

Females Only	
# of Pregnancies	
# of Living Children	
Miscarriages	
Abortions	
Pregnancy Complications?	

DO YOU	YES	NO	TYPE	AMT PER DAY/WEEK/YEAR
SMOKE			PIPE, CIGAR,CIGARETTES, CHEW	
EVER SMOKED			PIPE, CIGAR, CIGARETTES, CHEW	
DRINK COFFEE/TEA/COLAS				
DRINK BEER/WINE				
DRINK LIQUOR				
USE ILLEGAL DRUGS				

DO YOU EXERCISE ON A REGULAR BASIS? YES/NO WHAT TYPES? ___________________________________

DO YOU WORK OUTSIDE THE HOME? YES/NO IF SO, WHAT IS YOUR OCCUPATION? _______________________

IF YOU ARE DISABLED, PLEASE GIVE DATE YOU STOPPED WORKING____

FAMILY HISTORY OF: (Parents, Grandparents, Sisters, Brothers)

Arthritis _________ Psoriasis_________ Tuberculosis__________ Lung Disease__________

Lupus_____________ Cancer__________ Diabetes______________ Liver Disease__________

Osteoporosis______ Stroke__________ Migraines_____________ Thyroid Disorders______

Rheumatic Fever___ Kidney Disease____ High Blood Pressure____ Bleeding Disorders_____

Heart Disease_____

PATIENT NAME: ___________________________________ DATE: _____________________

SURGERY	YES	NO	WHEN	DETAILS
CATARACTS				
APPENDIX				
GALLBLADDER				
STOMACH				? CANCER
COLON				? CANCER
THYROID				
HERNIA				
BREAST				? CANCER
HYSTERECTOMY				? CANCER
OVARIES (ONE/BOTH)				
PROSTATE				? CANCER
TONSILS/ADENOIDS				
CARPAL TUNNEL				
BONE SURGERY				
DISC SURGERY				
HEMORRHOID				
OTHER				

PATIENT NAME: ______________________________ DATE: ____________________

REVIEW OF SYSTEMS

IF YOU PRESENTLY HAVE OR YOU HAVE HAD **RECURRENT** PROBLEMS WITH:

GENERAL	**CHECK HERE**	**KIDNEY/BLADDER**	**CHECK HERE**
Fever		Infections	
Appetite Change		Pain on Urination	
Weight Change (last 6-12 months)		Blood in Urine	
Unusual Fatigue		Kidney Stones	
Unusual Stress		Bright's Disease	
Sleeping Problems		Venereal Disease	
HEENT		**SKIN**	
Visual Problems (Blurring, Redness)		Rashes	
Cataracts		Hives	
Mouth or Nose Sores (recurrent)		Psoriasis	
Recurrent Sore Throat/Gland Swelling		Unusual Sensitivity to Sun	
Ringing in Ears		Skin Changes/Hair Loss	
Recurrent or Unusual Headaches		Skin Thickening/Skin Ulcers	
Dry Eyes **or** Dry Mouth **(circle which one)**		**NEUROLOGIC/PSYCHIATRIC**	
HEART		Muscle Weakness	
High Blood Pressure		Numbness/Tingling/Carpal Tunnel	
Irregular Heartbeat/Pacemaker		Sciatica (pain shooting down leg)	
Chest Pain or Heart Attack		Restless Legs	
Pericarditis (inflammation of the heart)		Seizures/Convulsions	
Heart Murmur		Confusion/Memory Loss	
Lungs		Depression/Anxiety/Panic Attacks	
Persistent Cough		Stroke	
Shortness of Breath		Sleep Apnea/Loud Snoring	
Pleurisy		**BLOOD DISORDERS**	
Tuberculosis or exposure to		Anemia	
Positive TB Skin Test		Low White Blood Cells	
Blood Clots in Legs/Phlebitis		Low Platelets	
GASTROINTESTINAL		**ENDOCRINE**	
Nausea/Vomiting		Thyroid Disease	
Swallowing Difficulty		Breast Problems	
Stomach Ulcers/Peptic Ulcers		Diabetes	
Esophagitis/Gastritis/Gastroesophageal (Acid) Reflux (GERD)		Heat/Cold Intolerance	
Blood in Stools		Age of Menopause	
Diarrhea		Change in Sexual Function	
Abdominal Pain		Sores/Rashes on Sex Organs	
Hepatitis		Low Blood Sugar	
Jaundice		Loss of Height	
INJURIES/BROKEN BONES		Have you ever taken estrogen? If so, how long?	
X-Rays – MRI/CT/BONE SCAN		Have you ever had a DXA or Bone Density Test?	
Chest x-ray in the past year			

Health Assessment Questionnaire

Name: ______________________________ Date: ______________________________

DOB: ______________________________ Physician: __________________________

PLEASE CHECK THE RESPONSE THAT BEST DESCRIBES YOUR ABILITIES RECENTLY (the past week):

	No Difficulty (0)	Some Difficulty (1)	Much Difficulty (2)	Unable to Do (3)
DRESSING & GROOMING – are you able to:				
Dress yourself, including shoelaces and buttons?	O	O	O	O
Shampoo your hair?	O	O	O	O
ARISING – are you able to:				
Stand up from a straight chair?	O	O	O	O
Get in and out of bed?	O	O	O	O
EATING – are you able to:				
Cut your meat?	O	O	O	O
Lift a full cup or glass to your mouth?	O	O	O	O
Open a new milk carton?	O	O	O	O
WALKING – are you able to:				
Walk outdoors on flat ground?	O	O	O	O
Climb up five steps	O	O	O	O
HYGIENE – are you able to:				
Wash and dry your body?	O	O	O	O
Get on and off the toilet?	O	O	O	O
REACH – are you able to:				
Reach and get down a 5-pound object (Such as a bag of sugar) from above your head?	O	O	O	O
Bend down to pick up clothing from the floor?	O	O	O	O
GRIP – are you able to:				
Open car doors?	O	O	O	O
Open previously opened jars?	O	O	O	O
Turn faucets on and off?	O	O	O	O
ACTIVITIES – are you able to:				
Run errands and shop?	O	O	O	O
Get in and out of a car?	O	O	O	O
Do chores such as vacuuming or yard work?	O	O	O	O

How much pain have you had because of your arthritis in the past week? (Please circle the number below).

No Pain Severe Pain

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Physician Use Only

Pain Score: _______________ Checklist Score: _______________

TOTAL HAQ SCORE: __________________

Rheumatology Associates of East TN — Review of Systems

Patient Name: ______________________________________ Date of birth: ______________________________

Any new medications: ____

Primary Care Doctor: ____

PLEASE CIRCLE ALL THAT APPLY:

Constitutional:

All negative	Feeling Poorly	Other
Fever	Chills	
Feeling Tired	Recent Wt Gain (___Lbs)	
Recent infection	Recent Wt Loss (___Lbs)	

Eyes:

All negative	Cataract	Other
Dry Eyes	Discharge from eyes	
Red Eyes	Eye Pain	
Eyesight Problems	Eye itch	

ENT:

All Negative	Nosebleeds	Other
Mouth Sores	Sore Throat	
Dry Mouth	Hoarseness	Loss of Hearing
Nose Sores	Ringing in the Ears	Chronic/recurring headaches

Cardiovascular:

All Negative	Palpitations	Other
Chest pain	Leg Claudication	
Lower Extremity Edema	Heart rate slow	Heart rate fast

Respiratory:

All Negative	SOB on Exertion	Other
Shortness of Breath	Orthopnea	
Cough	Wheezing	
Pleurisy	PND (waking up breathless)	

Gastrointestinal:

All Negative	Constipation	Other
Abdominal Pain	Stool visible blood	
Nausea	Gastric Ulcer	Diarrhea
Esophageal Reflux	Heartburn	
Difficulty Swallowing	Vomiting	

Genitourinary:

All Negative	Hesitancy	Other
Dysuria	Nocturia	
Blood in Urine	Recurrent Infections	Testicular Pain
Incontinence	Genital Lesions	

Patient Name: ___________________________________

Musculoskeletal:

All Negative	Joint Stiffness	Other
Arthralgias	Limb Pain	
Myalgias	Limb Swelling	
Morning Joint Stiffness	Muscle spasms	
Joint Swelling		

Integumentary:

All Negative	Itching	Other
Dry Skin	Abnormal skin sensitivity to sunlight (photosensitivity)	
Loss of hair from head	Skin Lesions	
Skin: A rash	Skin Wound	
Ulcer (___cm)		

Neurological:

All Negative	Confusion	Other
Convulsions	Legs Feel Restless	
Memory lapses or loss	Dizziness	Muscle Weakness
Numbness	Fainting	
Difficulty Walking	Pain radiating down the ___________	

Psychiatric:

All Negative	Panic Disorder	Other
Sleep Disturbances	Suicidal	
Anxiety	Change in Personality	
Depression	Emotional Problems	

Endocrine:

All Negative	Proptosis	Other
Heat/Cold Intolerance	Decrease in height	
Low Blood Sugar	Erectile Dysfunction	Deepening of the voice
DEXA (date ________)	Hot Flashes	Feeling of Weakness

Heme/Lymph:

All Negative	Swollen Glands in Neck	Other
Easy Bruising	Easy Bleeding	