Chart:_____
Phys.:_____
Date:_____

GARNER RHEUMATOLOGY
& INFUSION CENTER

810 Timber Drive, Garner, NC 27529 • Tel 919-747-9040 • Fax 1-866-837-8477
www.garnerrheumatology.com

PATIENT HEALTH HISTORY FORM

Patient Information			
First Name	Last Name	Middle Initial	Date of Birth
Height:	Weight:	Sex: ☐ Male ☐ Female	
Marital Status			
Describe briefly your present symptoms:			
Date (approximate) symptoms began:			
Previous Diagnosis and Treatment:			

Family History (Please Check the Box if Your Family Has a History Of):						
	Father	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Myositis	☐	☐	☐	☐	☐	☐
Vasculitis	☐	☐	☐	☐	☐	☐
Sarcoidosis	☐	☐	☐	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐
Polymyalgia Rheumatica	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Review of Systems (Please Check All Boxes That Apply to You):

Constitutional
☐ Fever
☐ weight loss
☐ fatigue

Eyes
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dry eyes

Ears/Nose/Mouth/Throat
☐Sinusitis
☐Asthma
☐Loss of hearing
☐ Ringing in the ears
☐ Nosebleeds
☐ Sores in mouth
☐ Dry mouth
☐ Difficulty swallowing

Cardiovascular
☐ Chest pain
☐ Heart palpitations
☐ High blood pressure

Respiratory
☐ Shortness of breath
☐ Cough
☐ Coughing of blood
☐ Wheezing (asthma)

Gastrointestinal
☐ Nausea
☐ Vomiting
☐ Blood in stools
☐ Black stools
☐Heartburn

Genitourinary
☐Blood in urine
☐Cloudy urine
☐Genital ulcers

Musculoskeletal
☐ Morning stiffness
☐ Joint pain (List joints)
_____
_____
_____
☐Muscle weakness

Integumentary
☐Rash
☐ Easy bruising
☐ Sun sensitive
☐ Skin tightness
☐ Hair loss
☐ Color changes in finger/toes

Neurological
☐ Headache
☐ Numbness
☐ Dizziness

Psychiatric
☐ Depression
☐ Anxiety
☐ Difficulty falling asleep
☐ Waking up tired in the morning

Endocrine
☐ Diabetes
☐ Night sweats

Hematologic/Lymphatic
☐ Bleeding tendency
☐ Anemia

Immunologic/allergic
☐ Frequent infections
☐ Hives

Personal Medical History (Please Check All Boxes That Apply to You):

☐ Rheumatoid Arthritis
☐ Psoriatic Arthritis
☐ Osteoporosis
☐ Broken Bones After 50
☐ Polymyositis
☐ Dermatomyositis
☐ Raynaud's Syndrome
☐ Lupus
☐ Ankylosing Spondylitis
☐ Vasculitis
☐ Sjogren's Syndrome
☐ Giant Cell Arteritis
☐ Polymyalgia Rheumatica

☐ Gout
☐ Rheumatic Fever
☐ Mixed Connective Tissue Disease
☐ Sarcoidosis
☐ Psoriasis
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Diabetes
☐ Peptic Ulcer Disease
☐ Degenerative Disc Disease
☐ Osteoarthritis (specify joint)
_____
☐ Hypothyroidism
☐ Carpal Tunnel Syndrome

☐ Cancer
Type_____
Year of diagnosis_____
Treatment_____
☐Multiple Sclerosis
☐ Tuberculosis
Were you treated?_____
If yes, year of treatment_____

☐ Frequent Infections
☐ Coronary Artery Disease
☐ Hepatitis B or C
☐ Emphysema/asthma
☐ Congestive Heart Failure

Orthopedic Surgery:

	Date
1.	
2.	
3.	
4.	
5.	
6.	

Current Medication(s) (Including Vitamins and Supplements):				
Medication Name	**Reason for Taking**	**Dosage**	**Frequency**	**Date Started**
1.				
2.				
3.				
4.				
5.				

*Please attach separate pages if taking more than 5 medications.

Allergies:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Social History:	
☐ Yes ☐ No	Do you smoke or have you ever smoked? If yes, how much per day and for how long?
☐ Yes ☐ No	Do you exercise? If yes, how often?
☐ Yes ☐ No	Do you drink alcohol? Type: Amount:
☐ Yes ☐ No	Do you diet? Salt intake: Fat Intake:
☐ Yes ☐ No	Do you come in contact with blood/bodily fluid at work?
☐ Yes ☐ No	Are you sexually active? If yes, with more than one partner?

Sleep Habits:	
☐ Yes ☐ No	Do you have difficulty falling asleep?
☐ Yes ☐ No	Do you have difficulty staying asleep?
☐ Yes ☐ No	Do you snore?
☐ Yes ☐ No	Do you awaken early in the morning?
☐ Yes ☐ No	Do you have daytime drowsiness?
☐ Yes ☐ No	Other:

Patient Signature:_____ Date: _____

Print Name:_____

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BONE DENSITOMETRY FORM

Patient Information			
First Name	Last Name	Middle Initial	Date of Birth
Height:	Weight:	Sex: ☐ Male ☐ Female	
What was your maximum height?			

FOR FEMALE PATIENTS ONLY:		
Have you gone through menopause? ☐ Yes ☐ No	If yes, age at menopause:	Do you take estrogen replacement? ☐ Yes ☐ No
Have you ever had a hysterectomy? ☐ Yes ☐ No	If no, did you ever take estrogen replacement? ☐ Yes ☐ No If yes, for how many years?	

All Patients:		
Have you had any x-ray procedures with contrast in the past 7 days?		☐ Yes ☐ No
Do you have chronic back pain?		☐ Yes ☐ No
Do you have any close blood relatives with osteoporosis or a Dowager's hump?		☐ Yes ☐ No
Did either of your parents have a hip fracture?		☐ Yes ☐ No
Have you ever had a fracture?	☐ Yes ☐ No ; If so, what part of the body? Age at fracture:	
Have you noticed loss in height?	☐ Yes ☐ No ; If so, how much?	
Have you had any joint replacements?	☐ Yes ☐ No ; If yes, which joints?	
Describe your dairy intake:	☐ LOW (Less than 1-2 servings per day) ☐ MEDIUM (3-5 servings per day) ☐ HIGH (more than 5 servings per day)	
Please Describe your level of physical activity:	☐ LOW ☐ MODERATE ☐ VERY ACTIVE	
Do you take calcium supplements?	☐ Yes ☐ No If so, how much per day? mg If you take calcium supplements, how long have you been on them?	
Have you taken corticosteroids for any prolonged period of time?	☐ Yes ☐ No ; If yes, for how long?	
Have you ever been on thyroid replacement?	☐ Yes ☐ No ; If yes, for how long?	
Have you ever been bedridden for longer than two weeks?	☐ Yes ☐ No ; If yes, for how long?	
Do you smoke?	☐ Yes ☐ No ; If no, have you ever smoked? ☐ Yes ☐ No	
Do take, or have you ever taken, any of the following:	☐ FOSAMAX ☐ MIACALCIN ☐ RECLAST ☐ FORTEO ☐ ACTELVIA ☐ EVISTA ☐ PROLIA ☐ BONIVA	
Please list any chronic medical problems you have:		