Mecklenburg Medical Group

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Date of First Appointment: ____/____/____ (MONTH DAY YEAR) Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT. #) Age: _____ Sex: ____ F ____ M

_____ (CITY STATE ZIP) Telephone: Home ( ) _____

Work ( ) _____

Referred here by: (check one)

____ Self ____ Family ____ Friend ____ Doctor ____ Other Health Professional

Name of person making referral _____

The name of the physician providing your general medical care? _____

Do you have an orthopedic surgeon? ____ Yes ____ No. If yes, Name _____

Describe briefly your present symptoms:

_____

_____

_____

_____

Date symptoms began (approximate) _____ Diagnosis given? (Please list) _____

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: _____

_____

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 (type unknown)	_____	____	Lupus or "SLE"	_____
____	Osteoarthritis	_____	____	Ankylosing spondylitis	_____
____	Rheumatoid Arthritis	_____	____	Childhood arthritis	_____
____	Gout	_____	____	Osteoporosis	_____

Other arthritis conditions: _____

PAST PERSONAL HISTORY:

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

Cancer _____	Heart Problems _____	Asthma _____	Goiter _____
Leukemia _____	Stroke _____	Cataracts _____	Diabetes _____
Epilepsy _____	Nervous breakdown _____	Stomach ulcers _____	Rheumatic Fever _____
Bad Headaches _____	Jaundice _____	Colitis _____	Kidney Disease _____
Pneumonia _____	Psoriasis _____	Anemia _____	

Other Significant Illness (Please list) _____

Previous Operations:

	Type	*Year*	*Surgeon*	*C*
1)				
2)				
3)				
4)				
5)				
6)				
7)				

Any previous fractures? ☐ No ☐ Yes Describe _____

Any other serious injuries? ☐ No ☐ Yes Describe _____

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of children _____ Number Living _____ Number Deceased _____ List ages of each _____

Serious illnesses 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 _____		

MARITAL STATUS:

_____ Never Married _____ Married _____ Divorced _____ Separated

Spouse _____ Alive/Age_____ _____ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended)*

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

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

HOME CONDITIONS

Check one: ☐ House ☐ Apartment

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

Number of people in household _____ Relationship, and age of each? _____

Who does most of the housework? _____ Who does most of the 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 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 other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)			

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 _____

SYSTEMS REVIEW

As you review the following list, **please check any of those problems which apply to you.**

GENERAL:
_____ Recent weight gain/Amount
_____ Recent loss of weight/Amount
_____ Fatigue
_____ Weakness
_____ Fever

NERVOUS SYSTEM:
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands and/or feet
_____ Memory loss

EARS:
_____ Ringing in ears
_____ Loss of hearing

EYES:
_____ Pain
_____ Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feels like something in eye

NOSE:
_____ Nosebleeds
_____ Loss of smell
_____ Dryness

MOUTH:
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

THROAT:
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing

Date of last eye examination _____
Date of last chest X-Ray _____
Date of last Tuberculosis Test _____

NECK:
_____ Swollen glands
_____ Tender glands

HEART AND LUNGS:
_____ Pain in chest
_____ Irregular heart beat
_____ Sudden changes in heart beat
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ Night sweats

STOMACH AND INTESTINES:
_____ Nausea
_____ Vomiting of blood or coffee ground material
_____ Stomach pain relieved by food or milk
_____ Yellow jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Black stools
_____ Heartburn

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 (sun allergy)
_____ Tightness
_____ Nodules/bumps
_____ Hair loss
_____ Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES:
_____ Morning stiffness
Lasting how long
_____ Minutes
_____ Hours
_____ Joint pain
_____ Muscle weakness
_____ Muscle tenderness
_____ Joint swelling –
List joints affected in the last 6 months:

_____
_____
_____
_____
_____
_____

HABITS:
Do you drink coffee? _____
Cups per day? _____
Do you smoke? __ Yes __ No __ Past
Cigarettes per day? _____
Has anyone ever told you to cut down on your drinking? ____ Yes ____ No
Do you use drugs for reasons that are not medical? If so, please list:

_____
_____
How many pillows do you use to sleep on each night? _____
Do you get enough sleep at night?
Yes _____ No _____
Do you wake up feeling rested?
Yes _____ No _____

MENSTRUAL:
Age when periods began: _____ . Periods regular: _____ Yes _____ No. How many days apart: _____ . Date of last period: _____ .
Date of last Pap smear: _____ . Bleeding after menopause: _____ .

Please review the list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the result 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	Results			Reactions
		A Lot	Some	Not At All	
1. Aspirin					
2. Disalcid/Trilisate					
3. Tylenol (plain)					
4. Tylenol with Codeine					
5. Darvon/Darvocet Wygesic					
6. Hydrocodone/Vicodin/ Lorcet					
7. Ultram					
8. Clinoril/Sulindac					
9. Feldene/Piroxican					
10. Indocin/Indomethacin					
11. Meclomen					
12. Motrin/Rufen/Advil					
13. Nalfon					
14. Naproxen/Aleve					
15. Ansaid/Flurbiprofen					
16. DayPro/Oxaprozin					
17. Lodine/Etodolac					
18. Orudis/Oruvail Ketoprofen					
19. Relafen/Nabumetone					
20. Toradol					
21. Voltaren/Cataflam Diclofenac					
22. Prednisone/Cortisone					
23. Colchicine/Benemid					
24. Zyloprim/Allopurinol					
25. Azulfidine/Sulfasalazine					
26. Gold (shots/pills)					
27. Minocin/Minocycline					
28. Methotrexate					
29. Plaquenil/Hydroxychloroquine					
30. Imuran/Azathioprine					
31. Penicillamine					
32. Cyclosporine/Cytoxan					
33. Other					
34. Other					
35. Other					

MEDICATIONS

DRUG ALLERGIES: _____ No _____ Yes To What? _____

Type of reaction? _____

Present: (List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and 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.					
11.					
12.					

NOTES