Greensboro Medical Associates, PA

1511 Westover Terrace · Suite 201 · Greensboro, NC 27408

Date of first appointment: _____/_____/_____

Name: _____
Last First Middle Initial Maiden

Month Day Year

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 names of other practitioners you have seen for this problem: _____

_____

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?_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY:

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_____

SYSTEMS REVIEW:

Please check any of the below listed 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 heartbeat
_____Sudden changes in heartbeat
_____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—
Joints affected in the past 7 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:_____

PAST PERSONAL HISTORY:

Do you now have 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	City
1)				
2)				
3)				
4)				
5)				

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 has had (check and give relationship):

Cancer_____ Heart disease_____ Rheumatic fever_____ Tuberculosis_____

Leukemia_____ High blood pressure_____ Epilepsy_____ Diabetes_____

Stroke_____ Bleeding tendency_____ Asthma_____ Goiter_____

Colitis_____ Alcoholism_____

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 your 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 a 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?……_____ _____ _____

With 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

MEDICATIONS:

DRUG ALLERGIES: _____Yes _____No If 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)					

Past: 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.

Drug Names/Dosage	Length of Time	Results			Reactions
		A Lot	Some	Not At All	
1) Aspirin					
2) Aspirin-containing product					
3) Easprin					
4) Disalcid					
5) Tylenol (plain)					
6) Tylenol with codeine					
7) Darvon/Darvocet					
8) Clinoril					
9) Feldene					
10) Indocin					
11) Meclomen					
12) Motrin/Rufen					
13) Nalfon					
14) Naprosyn					
15) Tolectin					
16) Cortisone/Prednisone					
17) Benemid					
18) Colchicine					
19) Zyloprim/Lopurin					
20) Gold (shots or pills)					
21) Plaquenil					
22) Penicillamine					
23) Methotrexate					
24) Imuran					
25) Cytoxan					
26) Other					