INOVA

2QUESTI

Name: _____ Date: _____

Do you have trouble hearing or understanding information over the phone? ☐ Yes ☐ No

What is your preferred language? _____

Presenting Problem(s)

Please explain what you are being seen for today: _____

_____

_____

I. Medical History

A. Medical Problems – Have you ever been diagnosed with any of the following?

☐ Heart Disease
- ☐ Heart Attack (MI) ☐ Congestive heart failure ☐ Arrhythmia
- ☐ Atrial fibrillation ☐ Angina ☐ Coronary artery disease
- ☐ Ischemic heart disease ☐ Cardiomyopathy ☐ Pericarditis
- ☐ Pericardial effusion ☐ Rheumatic fever ☐ Heart murmur
- ☐ Valvular heart disease (Mitral regurgitation, Mitral stenosis, Aortic insufficiency, Aortic stenosis)
- ☐ Other: _____

☐ Lung Disease
- ☐ Emphysema ☐ COPD ☐ Asthma
- ☐ Pulmonary fibrosis ☐ Interstitial lung disease ☐ Sleep apnea
- ☐ Pleural effusion ☐ Pulmonary hypertension ☐ Sarcoidosis
- ☐ Pleurisy ☐ Other: _____

☐ Kidney Disease
- ☐ Nephritis ☐ Renal insufficiency ☐ Renal failure
- ☐ Kidney stones ☐ Other: _____

☐ Liver Disease
- ☐ Hepatitis ☐ Cirrhosis ☐ Other: _____

☐ Gastrointestinal (GI) Disease:
- ☐ Reflux/Esophagitis ☐ GI bleed ☐ Irritable bowel syndrome
- ☐ Ulcer disease ☐ Diverticular disease ☐ Gastric ulcer
- ☐ Duodenal ulcer ☐ Diverticulosis ☐ Diverticulitis
- ☐ Colitis ☐ Gallbladder disease (gall stones)
- ☐ Other: _____

☐ Edema

☐ Cancer
- ☐ Colon ☐ Breast ☐ Lung ☐ Stomach ☐ Brain ☐ Prostate
- ☐ Pancreatic ☐ Ovarian ☐ Cervical ☐ Uterine ☐ Testicular ☐ Bone
- ☐ Lymphoma ☐ Leukemia ☐ Other: _____

☐ Diabetes Type: _____

☐ Thyroid disorder Type: _____

☐ Blood disorder
- ☐ Anemia ☐ Low white count ☐ Low platelet count
- ☐ Other: _____

☐ Neurological or Muscular Disorder
- ☐ Stroke/TIA ☐ Seizures ☐ Migraine headaches
- ☐ Multiple sclerosis ☐ Neuropathy ☐ Carpal tunnel syndrome
- ☐ Polymyositis ☐ Muscular dystrophy ☐ Other: _____

If label is not available, please complete:

Patient Name: _____

DOB: _____ MR# _____

Inova Medical Group

Rheumatology Medical History

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☐ High blood pressure
☐ Elevated cholesterol or other hyperlipidemia
☐ Blood Clot
  ☐ Deep venous thrombosis ☐ Pulmonary embolism ☐ Other: _____

☐ Serious Infection(s)
  ☐ Pneumonia ☐ Endocarditis ☐ Tuberculosis
  ☐ Septicemia ☐ Pyelonephritis ☐ Abscess
  ☐ Other: _____

☐ Psychiatric Disorder
  ☐ Anxiety ☐ Depression ☐ Bipolar disorder
  ☐ Schizophrenia ☐ Other: _____

☐ Arthritis
  ☐ Degenerative joint disease ☐ Osteoarthritis ☐ Rheumatoid arthritis
  ☐ Lupus ☐ Gout ☐ Pseudogout
  ☐ Connective tissue disease ☐ Spondyloarthopathy ☐ Ankylosing spondylitis
  ☐ Scleroderma ☐ Sjogren's syndrome
  ☐ Polymyalgia rheumatica (PMR) ☐ Other: _____

☐ Sexually Transmitted Disease:
  ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis
  ☐ Other: _____

☐ Immune Deficiencies Type: _____

☐ Osteoporosis or Osteopenia Have you ever had a bone density test? _____
If yes, when: _____ Where: _____

B. Surgeries – Please list any procedures you have had including orthopedic procedures. Also include the date. Please attach a separate sheet of paper if more room is necessary.

Procedure: _____ Date: _____
Procedure: _____ Date: _____

C. Other Hospitalizations – Please attach a separate sheet of paper if more room is necessary. Please list any other hospitalizations, reason for hospitalization, approximate date and which hospital:

Reason: _____ Date: _____ Hospital: _____
Reason: _____ Date: _____ Hospital: _____

D. Serious Injuries – Please list any serious injuries especially musculoskeletal injuries. Include approximate date. Attach a separate sheet of paper if more room is necessary.

Injury: _____ Date: _____
Injury: _____ Date: _____

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Current Medications: Please include prescription and over the counter medications, as well as supplements and vitamins. If you have a medication list, please attach. If you do not have a medication list, please bring your medication bottles with you to your first appointment

Name	Dose	Times/Day	Reason	Start Date

Allergies to Medications: ☐ None

Name _____ Type of Reaction _____ Mild/Moderate/Severe

Name _____ Type of Reaction _____ Mild/Moderate/Severe

II. Family History

Has any BLOOD relative ever been diagnosed with any of the following, please list relationship:

Arthritic Disorder (please list type if known): ☐ Yes ☐ No

Lupus ☐ Yes ☐ No Connective Tissue Disease ☐ Yes ☐ No

Gout ☐ Yes ☐ No Osteoporosis ☐ Yes ☐ No

Cancer ☐ Yes ☐ No type: _____

Other: _____

III. Social History

Marital status _____ Who do you live with? _____

Highest education level _____ Occupation _____

Do you have a support system at home? _____ Who? _____

Have you ever smoked? _____ Do you currently? _____ If yes how much and how long? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use illicit/street drugs? _____ If yes, which ones? _____

Do you drive? _____ Do you exercise regularly? _____ Do you have any tattoos? _____

Have you had any recent falls at home? _____ Can you care for yourself? _____

Do you have any concerns with any self-care or activities of daily living? _____

Do you require aids or assistive devices for mobility? _____

Can you walk 100 yards? _____

If label is not available, please complete:

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IV. Review of Systems – Please indicate if you have had any trouble with the following over the past 5 years:

Hair loss (Alopecia) ☐ Yes ☐ No If Yes: ☐ Generalized ☐ Thinning ☐ Patchy
Oral or nasal ulcers ☐ Yes ☐ No
Rash ☐ Yes ☐ No Type: _____ Area(s): _____ When: _____
Psoriasis ☐ Yes ☐ No
Photosensitivity (any rash with sun exposure) ☐ Yes ☐ No
Raynauds – Hands, fingers, feet or toes turn blue or white with cold exposure ☐ Yes ☐ No
Sicca Sx – severe dry eyes or dry mouth ☐ Yes ☐ No

Low or abnormal blood count
- Anemia ☐ Yes ☐ No
- Low Platelet Count ☐ Yes ☐ No
- Low White Blood Count ☐ Yes ☐ No

Pleurisy or Pericarditis (inflammation of the lining of the lungs or heart) ☐ Yes ☐ No
Inflammatory eye disorder
- Iritis ☐ Yes ☐ No
- Conjunctivitis ☐ Yes ☐ No
- Uveitis ☐ Yes ☐ No

Hematuria or Proteinuria (history of blood or protein in urine) ☐ Yes ☐ No
Blood clot ☐ Yes ☐ No

Gastrointestinal Symptoms
- Abdominal pain ☐ Yes ☐ No
- Vomiting ☐ Yes ☐ No
- GI bleeding ☐ Yes ☐ No
- Difficulty swallowing ☐ Yes ☐ No
- Nausea ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Colitis ☐ Yes ☐ No

Neurological Symptoms
- Headaches ☐ Yes ☐ No
- Loss of appetite ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No
- Visual symptoms ☐ Yes ☐ No
- Unintentional weight loss ☐ Yes ☐ No
- Numbness or tingling in extremities *(parasthesias)* ☐ Yes ☐ No
- Cramping in jaw muscles while chewing *(jaw claudication)* ☐ Yes ☐ No
- Pain in jaw *(TMJ; Temporomandibular joint)* ☐ Yes ☐ No
- Difficulty sleeping *(Sleep disturbance of any kind)* ☐ Yes ☐ No
- Fever *(temperature elevation)*, chills, sweating

Respiratory Symptoms
- Shortness of breath ☐ Yes ☐ No
- Coughing up blood ☐ Yes ☐ No
- Cough – dry or productive ☐ Yes ☐ No
- Chest pain with breathing (pleuritic pain) ☐ Yes ☐ No

Musculoskeletal Symptoms
- Joint pain ☐ Yes ☐ No
- Joint swelling ☐ Yes ☐ No
- Back pain ☐ Yes ☐ No
- Muscle weakness ☐ Yes ☐ No
- Joint stiffness ☐ Yes ☐ No
- Joint loss of motion ☐ Yes ☐ No
- Muscle pain ☐ Yes ☐ No
- Nodules/lumps/bumps under the skin ☐ Yes ☐ No

WOMEN ONLY

Pregnancies: Are you currently pregnant? ☐ Yes ☐ No _____ weeks
- Number of pregnancies: _____
- Number of miscarriages: _____
- Number of deliveries: _____
- Number of abortions: _____
- Have you had any 2nd or 3rd trimester miscarriages? ☐ Yes ☐ No
- Do you use birth control? ☐ Yes ☐ No
- Do you plan to have any more children? ☐ Yes ☐ No
- Age of menopause (if applicable) _____

If label is not available, please complete:

Patient Name: _____

DOB: _____ MR# _____

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Rheumatology Medical History

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