St. Francis Medical Group

Rheumatology & Osteoporosis Specialists at St. Francis
New Patient History

MRN ______________________ Date ______________________

Patient's Name ______________________ DOB ______________ Age ________

Physician Stefan Monev, MD

Date of first appointment ______ / ______ / ______ (month / day / year) Birthplace ______________________

Sex: ☐ Female ☐ Male

Name of physician making referral ______________________

The name of the physician providing your general medical care: ______________________

Do you have an orthopedic surgeon? ☐ yes ☐ no if yes, name ______________________

What is the chief problem which brings you to this office? (Please be brief) ______________________

How long have you had this problem? ______________________

What diagnosis has been given? ______________________

What do you think is causing the problem? ______________________

Previous treatments for this problem that you have received (include physical therapy, surgery, injections) Your medications will be listed on the following page:

Please list the names and addresses (if known) of any other physicians or providers you have seen for this problem: ______________________

Drug allergies? ☐ yes ☐ no If yes,

	Name of drug	Reaction		Name of drug	Reaction
1.			4.		
2.			5.		
3.			6.		

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MEDICATIONS:

Present: *(List any medications that you are taking* ***at this time,*** *including such items as aspirin, vitamins, artificial tears, calcium supplements, etc.)*

Name of drug	Dose (include strength and number of pills per day)	Reason	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.						
13.						
14.						
15.						

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. Record your comments in the spaces provided.*

Drug names	Dosage	Length of time with approximate dates	Results			Reactions
			A lot	Some	Not at all	
1. Tylenol with codeine						
2. Darvon /Darvocet						
3. Vicodin (hydrocodone)						
4. Clinoril (sulindac)						
5. Feldene (piroxicam)						
6. Indocin (indomethacin)						
7. Motrin (ibuprofen)						
8. Naprosyn (naproxen)						
9. Oruvail /Voltaren (diclofenac)						
10. Relafen (nabumatone)						
11. Lodine (etodolac)						
12. Cortisone /prednisone						
13. Colchicine						
14. Zyloprim (allopurinol)						
15. Gold (shots or pills)						
16. Plaquenil (hydroxychloroquine)						
17. Methotrexate						
18. Imuran (azathiprin)						
19. Cytoxan (cyclophosphamide)						
20. Neoral / Sandimmune (Cyclosporin-A)						
21. Arava (leflunomide)						
22. Cellcept (mycophenolate)						
23. Enbrel						
24. Humira						
25. Remicade						
26. Orencia						
27. Fosamax (alendronate)						
28. Actonel (Risedronate)						

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PAST PERSONAL HISTORY

Have you ever had:	Circle Yes or No		Year	Have you ever had:	Circle Yes or No		Year
Meningitis	Yes	No	______	Bleeding tendency	Yes	No	______
Infectious mono	Yes	No	______	Low platelets	Yes	No	______
Tuberculosis (TB)	Yes	No	______	Blood transfusion	Yes	No	______
Exposure to TB	Yes	No	______	Herpes	Yes	No	______
Lyme disease	Yes	No	______	Hepatitis (yellow jaundice)	Yes	No	______
Hives	Yes	No	______	Ulcer (peptic)	Yes	No	______
Leukemia / Lymphoma	Yes	No	______	Colitis (diagnosed by	Yes	No	______
Cancer (skin & other)	Yes	No	______	colonoscopy and biopsy)	Yes	No	______
Psoriasis	Yes	No	______	Colon polyps	Yes	No	______
Back pain	Yes	No	______	Hemorrhoids	Yes	No	______
Thyroid /Goiter disease	Yes	No	______	Irritable bowel	Yes	No	______
Bronchitis	Yes	No	______	Urinary infection	Yes	No	______
Pneumonia	Yes	No	______	Kidney stones	Yes	No	______
Pleurisy	Yes	No	______	Kidney failure	Yes	No	______
Asthma	Yes	No	______	Glaucoma	Yes	No	______
Emphysema /COPD	Yes	No	______	Stroke	Yes	No	______
Sleep apnea	Yes	No	______	Nose bleeds	Yes	No	______
High blood pressure	Yes	No		Blood clots – legs	Yes	No	______
Since when?			______	Blood clots – lungs	Yes	No	______
Heart disease	Yes	No	______	AIDS	Yes	No	______
Heart attack	Yes	No	______	Radiation therapy	Yes	No	______
Heart murmur or	Yes	No	______	Chemotherapy	Yes	No	______
Valve disease	Yes	No	______	Diabetes	Yes	No	______
Anemia	Yes	No	______	Multiple sclerosis	Yes	No	______
Low white blood cell count	Yes	No	______	Celiac sprue	Yes	No	______

Other significant illness (please list) ______________________________

PREVIOUS SURGERIES

Type or Name of operation	Approximate year	Type or Name of operation	Approximate year
1. ______	______	6. ______	______
2. ______	______	7. ______	______
3. ______	______	8. ______	______
4. ______	______	9. ______	______
5. ______	______	10. ______	______

FRACTURES /INJURIES

Have you fractures any bones in your adult life? ☐ yes ☐ no

If yes, was there significant trauma causing fracture(s)? ☐ yes ☐ no

Please list and explain fractures (e.g., "I simply fell down and broke my hip.") ______________________

Any other serious injuries? ☐ yes ☐ no Describe: ______________________

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PAST PERSONAL HISTORY (continued)

Previous studies / date (Bring copies of recent test and x-ray results.)

- ☐ Chest x-ray ______
- ☐ Kidney /IVP ______
- ☐ Stomach /UGI ______
- ☐ Gall bladder ______
- ☐ Mammogram ______
- ☐ Biopsy of ______
- ☐ CT scan -head ______
- ☐ CT scan -other ______
- ☐ MRI ______
- ☐ Gastroscopy (EGD) ______
- ☐ Colonoscopy ______
- ☐ Cystoscopy ______
- ☐ Bronchoscopy ______
- ☐ Bone densitometry (DXA) ______
- ☐ Echocardiogram ______
- ☐ Ultrasound of ______
- ☐ Stress test ______
- ☐ EKG ______
- ☐ Angiogram ______
- ☐ Pulmonary function ______
- ☐ Other ______

FAMILY HISTORY

	If living:		If deceased:	
	Age	Health	Age at death	Cause of death
Father				
Mother				
Brothers or Sisters				
1.				
2.				
3.				
4.				
5.				
Children				
1.				
2.				
3.				
4.				
5.				

Has any blood relative had any of the following? If yes, what relationship?

	Circle Yes or No		Relationship
Bleeding tendency	Yes	No	
Blood clots	Yes	No	
Heart attack	Yes	No	
Stroke	Yes	No	
Emphysema /COPD	Yes	No	
Asthma	Yes	No	
Tuberculosis	Yes	No	
Alcoholism	Yes	No	
High blood pressure	Yes	No	
Thyroid disease /Goiter	Yes	No	
Kidney disease	Yes	No	
Diabetes	Yes	No	
Cancer	Yes	No	
Ulcerative colitis /Crohn's	Yes	No	
Rheumatoid arthritis	Yes	No	

	Circle Yes or No		Relationship
Psoriatic arthritis	Yes	No	
Psoriasis	Yes	No	
Lupus or "SLE"	Yes	No	
Osteoarthritis	Yes	No	
Arthritis (type unknown)	Yes	No	
Ankylosing spondylitis	Yes	No	
Childhood arthritis	Yes	No	
Polymyositis	Yes	No	
Dermatomyositis	Yes	No	
Gout	Yes	No	
Fibromyalgia	Yes	No	
Scleroderma	Yes	No	
Osteoporosis	Yes	No	
Fractures	Yes	No	
Other: ______	Yes	No	

MRN ______________________ Date ______________________

Patient's Name ______________________ DOB ______________ Age ________

SOCIAL HISTORY

EDUCATION *(circle the highest level completed)*: 7 8 9 10 11 high school graduate some college college graduate

Degree(s) earned: ______________________

MARTIAL STATUS: ☐ single ☐ married ☐ divorced ☐ widowed

OCCUPATION: ______________________ _____ years _____ hours per week Retired: ☐ yes ☐ no

Last worked: ______________________ Are you disabled from work? ☐ yes ☐ no

Are you receiving disability? ☐ yes ☐ no Are you applying for disability? ☐ yes ☐ no

Have you had an injury for which there is now a lawsuit pending? ☐ yes ☐ no

Previous /other occupations, hobbies ______________________

Exposure to hazardous materials? ☐ yes ☐ no

Type: ______________________

HOME CONDITIONS:

Check one: ☐ house ☐ apartment ☐ condo ☐ mobile home

Do you have stairs to climb? ☐ yes ☐ no If yes, how many? ____________

Number of people in household:

Relationship						
Age of each						

Who does most of the housework? ______________ Who does most of the shopping ______________

HABITS:

Tobacco use? ☐ yes ☐ no ☐ past Type and amount ______________________

Years __________ Tried to stop? ☐ yes ☐ no If quit, when? __________ Do you wish to stop? ☐ yes ☐ no

Alcohol (beer, wine, liquor)? ☐ yes ☐ no If yes, number of drinks per week ____________

Coffee, tea, cola beverages – amount per day __________ Any special diets? ______________

Travel: Where / when in last 2 years? ______________________

Exercise: Any exercise? ☐ yes ☐ walking ☐ aerobic type ☐ other ______________ How often? ____________

Specify any weight changes: ______________________

ACTIVITIES OF DAILY LIVING

One the scale below, circle a number which best describes your situation. Most of the time, I function…..

1	2	3	4	5
Very well	Well	Okay	Poorly	Very poorly

Please check the ONE best answer to each question below:

At this moment, are you able to:	Without any difficulty	With some difficulty	With much difficulty	**Unable** to do
a. Dress yourself, including tying shoelaces and doing buttons?	☐ 1	☐ 2	☐ 3	☐ 4
b. Get in and out of bed?	☐ 1	☐ 2	☐ 3	☐ 4
c. Lift a full cup or glass to your mouth?	☐ 1	☐ 2	☐ 3	☐ 4
d. Walk outdoors on flat ground?	☐ 1	☐ 2	☐ 3	☐ 4
e. Wash and dry your entire body?	☐ 1	☐ 2	☐ 3	☐ 4
f. Bend down to pick up clothing from the floor?	☐ 1	☐ 2	☐ 3	☐ 4
g. Turn regular faucets on and off?	☐ 1	☐ 2	☐ 3	☐ 4
h. Get in and out of a car?	☐ 1	☐ 2	☐ 3	☐ 4

Do you use (circle item) a cane crutches a walker a wheelchair

What is the hardest thing for you to do? ______________________

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SYSTEMS REVIEW: Have you recently had the following: Circle Yes or No; if in doubt, leave blank.

General (within 2 months)

Tire easily	Yes	No
Marked weight change	Yes	No
Soaking night sweats	Yes	No
Persistent fever ____ degrees	Yes	No

Skin

Sun sensitive (sun allergy)	Yes	No
Eruptions (rash)	Yes	No
Malar (butterfly) rash	Yes	No
Fingers /toes turn white or blue in the cold	Yes	No
Tightening or thickening of skin	Yes	No
Changes in nails	Yes	No
Unexplained hair loss	Yes	No
Nodules or bumps	Yes	No

Head / Neck

Recent /new onset of scalp pain or tenderness	Yes	No
Swollen glands	Yes	No
Tender glands	Yes	No

Eyes

Trouble seeing	Yes	No
Date of last eye exam ______________		
Eye pain	Yes	No
Dry eyes daily	Yes	No
Inflamed eyes	Yes	No
Use artificial tears	Yes	No
Feels like something is in eyes	Yes	No

Ears

Loss of hearing	Yes	No
Ringing or noises in ears	Yes	No

Nose

Sores ☐ painful ☐ painless	Yes	No
Loss of smell	Yes	No
Nosebleeds (frequent / severe)	Yes	No

Mouth

Mouth sores ☐ painful ☐ painless	Yes	No
Dry mouth daily	Yes	No
Jaw tiredness or pain when chewing	Yes	No

Throat

Postnasal drainage	Yes	No
Soreness	Yes	No
Hoarseness / change in voice	Yes	No

Breasts

Lumps	Yes	No
Discharge	Yes	No

Cardio-Respiratory System

Cough, persistent	Yes	No
Sputum (phlegm)	Yes	No

Cardio-Respiratory System (continued)

Bloody sputum	Yes	No
Wheezing	Yes	No
Chest pain or discomfort	Yes	No
Shortness of breath when sitting quietly	Yes	No
Shortness of breath after walking up 2 flights of stairs or hurrying	Yes	No
Difficulty breathing while lying down	Yes	No
Snoring or stop breathing momentarily during sleep	Yes	No
Swelling of ankles every day	Yes	No
Bluish fingers or lips	Yes	No
High blood pressure	Yes	No
How long? ____________ Recent B/P reading: ______ / ______		
Palpitations	Yes	No
Use supplemental oxygen	Yes	No
Vein trouble	Yes	No

Gastrointestinal

Change in appetite	Yes	No
Difficulty swallowing (food gets stuck on way down)	Yes	No
Frequent heartburn	Yes	No
Abdominal distress or pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Vomiting of blood or coffee- ground like	Yes	No
Rectal bleeding	Yes	No
Tarry stools	Yes	No
Jaundice (skin/ eyes turning yellow)	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No

Genitourinary

Increase in frequency of urination (day / night)	Yes	No
Unable to hold urine	Yes	No
Pain or burning when urinating	Yes	No
Blood in urine	Yes	No
Vaginal or penile sores	Yes	No
Impotence	Yes	No
Vaginal or penile discharge	Yes	No
Lack of sex drive	Yes	No
Prostate trouble	Yes	No
Venereal disease	Yes	No

Endocrine

Thyroid trouble or goiter	Yes	No
Adrenal trouble	Yes	No
Diabetes	Yes	No

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SYSTEMS REVIEW (continued)

Have you recently had the following: Circle Yes or No; if in doubt, leave blank.

Blood

Anemia	Yes	No
Low white count	Yes	No
Low platelets	Yes	No
Easy bruising	Yes	No
Bleeding tendency	Yes	No
Blood clots	Yes	No

Nervous System

Headaches (new, frequent or severe)	Yes	No
Dizziness ☐ spinning ☐ lightheadedness	Yes	No
Fainting / Loss of consciousness	Yes	No
Convulsions or fits	Yes	No
Difficulty going to sleep	Yes	No
Difficulty obtaining restful sleep	Yes	No
Depression	Yes	No
Anxiety / panic attacks	Yes	No

Nervous System (continued)

Change in sensation / tingling or numbness	Yes	No
Memory loss	Yes	No
Poor coordination: ☐ falls ☐ imbalance	Yes	No
Weakness or paralysis	Yes	No
Nighttime muscle cramps	Yes	No

Gyn - OB

Started menstruating at age ____________

Are menstrual periods normal?	Yes	No

Date of last menstrual period ____________

Periods regular?	Yes	No
Having "hot flashes"	Yes	No
Vaginal dryness	Yes	No
Have you used hormones?	Yes	No

Pregnancies ________ Deliveries _________

Miscarriages ________ Abortions _________

ARTHRITIS HISTORY

Have you experienced any of the following in the last several weeks?

a. Joint pain ☐ yes ☐ no If yes, which joints and how severe? ______________________

b. Joint swelling ☐ yes ☐ no If yes, which joints and how severe? ______________________

c. Muscle pain or tenderness ☐ yes ☐ no If yes, which muscles and how severe? ______________________

d. When you get up in the morning , do you feel stiff? ☐ yes ☐ no If yes, how long is it until you are as limber as you will be for the day? ________ minutes or _______ hours. Is your stiffness in your ☐ joints ☐ muscles ☐ both?

e. What factors or medications have provided relief of your pain? ______________________

f. What factors or activities cause (or increase) your pain? Please explain: ______________________

g. How much pain have you had in the PAST WEEK? Place a mark on the line below to indicate how severe your pain has been

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain is severe

h. How much of a problem is UNUSUAL fatigue or tiredness for you over the PAST WEEK?

0 1 2 3 4 5 6 7 8 9 10

Fatigue is no problem — Fatigue is major problem

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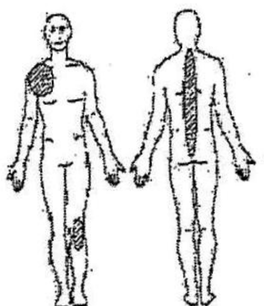
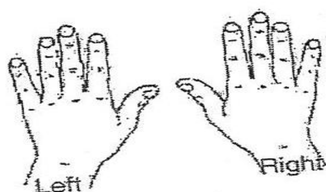
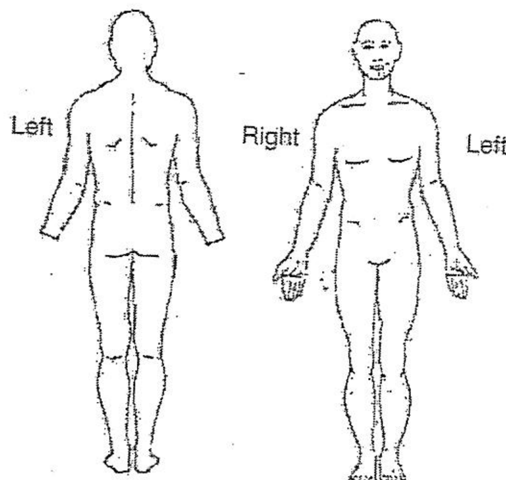
Please shade all the locations of your pain over the past week on the **body figures** and **hands**:

Example:







Factors That May Affect Learning

Who is to be taught: ☐ patient ☐ other; if other, relationship to patient______________ **Able to read:** ☐ yes ☐ no ☐ with difficulty Comments ______________________________ **Potential barriers to learning**: ☐ none ☐ blind ☐ poor vision ☐ deaf ☐ decreased hearing ☐ unable to talk ☐ learning disability ☐ inability to understand ☐ memory loss ☐ language, if other than English __________________ **Learns best by**: ☐ reading ☐ verbal instruction ☐ practicing ☐ talking ☐ watching ☐ other, ______________________ **Are there any cultural or religious beliefs that need to be considered in the care?** ☐ yes ☐ no. If yes, ______________________________

Signature ______________________________**Relationship to patient** ________________________**Date**_________