HENEIN
Arthritis & Osteoporosis Center, P.C.
Violette F. Henein, M.D.
Board Certified Rheumatologist

# RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? _____

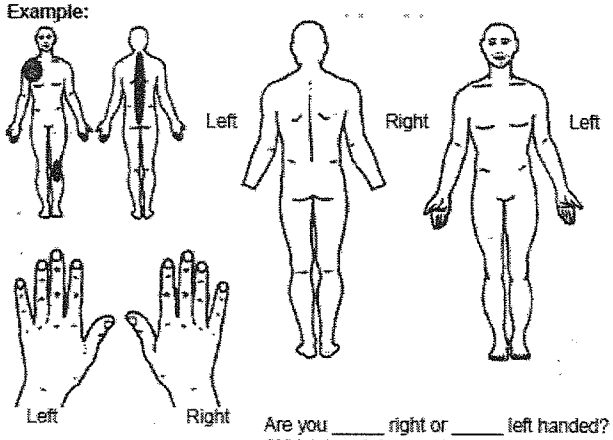
Name of your primary care physician: _____

Describe briefly your present symptoms: _____

When did your symptoms start? _____

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

Example:




Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

What diagnosis have you been given, if any?

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

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):



Physician initials _____

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

At any time have you or a blood relative had any of the following? (check if "yes")

| | Yourself | Relative | → | Name/relationship |
|---|---|---|---|---|
| Arthritis (type unknown) | ❑ | ❑ | → | _____ |
| Osteoarthritis | ❑ | ❑ | → | _____ |
| Rheumatoid arthritis | ❑ | ❑ | → | _____ |
| Gout | ❑ | ❑ | → | _____ |
| Lupus or "SLE" | ❑ | ❑ | → | _____ |
| Ankylosing spondylitis | ❑ | ❑ | → | _____ |
| Childhood arthritis | ❑ | ❑ | → | _____ |
| Sjogren's syndrome | ❑ | ❑ | → | _____ |
| Osteoporosis | ❑ | ❑ | → | _____ |
| Psoriasis/psoriatic arthritis | ❑ | ❑ | → | _____ |

**PAST MEDICAL HISTORY**

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

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other significant illnesses (please list): _____

**Previous Operations**

| | *Type* | *Year* | *Reason* |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No



Physician initials _____

**MEDICATIONS**

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

| Name of drug | Dose (include strength and number of pills per day) |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |
| 11. | |
| 12. | |

**PERSONAL HISTORY**

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate
❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?_____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

**FAMILY HISTORY**

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| | Age | Health | Age at death | Cause |
| Father | | | | |
| Mother | | | | |

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

_____



Physician initials _____

## SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

**GENERAL**
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

**MUSCLE/JOINTS/BONES**
- ❑ Morning stiffness
  - Lasting how long ____ Minutes
  - ____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

**EARS**
- ❑ Ringing in ears
- ❑ Loss of hearing

**EYES**
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

**MOUTH**
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

**NOSE**
- ❑ Nosebleeds
- ❑ Loss of smell

**THROAT**
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

**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
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing

**STOMACH AND INTESTINES**
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

**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
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

**NERVOUS SYSTEM**
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

**PSYCHIATRIC**
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

*For women only:*

Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _____



Physician initials _____

**Henein Arthritis & Osteoporosis Center, P.C.**
**PATIENT REGISTRATION FORM**

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Patient Name:_____ Social Security No: _____-_____-_____

Date of Birth:__/____/___ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address:_____
(Street) (City/State/Zip)
Home Phone : (____) _____ Mobile Phone (_____) _____
Driver License No._____
Employer Name:_____ Employer Ph #:(____)_____
Employer Address:_____
(Street) (City/State/Zip)

**Primary Care Physician:**_____ Phone #:_____
Address: _____

**Referring Physician:**_____ Phone #: _____
Address: _____

How did you hear about our practice?_____

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Person Responsible for bill or Parent (Complete only if different from patient)
Guarantor Name:_____ Social Security No.:_____-_____-_____
Relationship to patient: (Please check): ()self ()spouse () parent Date of Birth: ____/____/____
Address:_____ Phone No:_____
Employer Name:_____ Employer Ph #:(____)_____
Employer Address:_____
(Street) (City/State/Zip)

**Who to call for an emergency:**
Name:_____ Relationship:_____
Address:_____
Home #:_____Work #:_____Cell #:_____

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**FIRST INSURANCE INFORMATION**
Plan Name:_____
Policy Holder:_____
Policy Holder's Social Security No: _____
Policy Holder's Date of Birth:_____ Sex M/F

**SECOND INSURANCE INFORMATION**
Plan Name:_____
Policy Holder:_____
Policy Holder's Social Security Number: _____
Policy Holder's Date of Birth:_____ Sex M/F

**IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y/N**

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I authorize the release of any medical information necessary to process this bill/claim to my insurance company, and request payment of benefits to **Henein Arthritis & Osteoporosis Center, P.C.** for the services provided. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature:_____Date:_____

**HENEIN ARTHRITIS AND OSTEOPOROSIS CENTER, P.C.**
39621 Garfield Road, Clinton Township MI 48038
Phone 586-226-5555 - Fax 586-226-4441

# Authorization to Obtain Medical Records

I authorize **Henein Arthritis and Osteoporosis Center** to obtain any/all medical records necessary in the treatment of my medical condition from physicians that I am currently treating with or from physicians I may have been previously treated by in the past.

Signature of patient/legal guardian or responsible party if a minor

Printed name of patient

Date of Birth

Date: _____

This provision will remain in effect until I provide written revocation to **Henein Arthritis and Osteoporosis Center.**

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