Name: _____ Date: _____

Main Line Rheumatology & Osteoporosis

Social History

Age: ____ DOB:_____Occupation:_____

Marital Status: ❑ M ❑S ❑D ❑W Number of Children _____ Ages: _____

Do You Smoke ❑ Yes ❑ No	**Do you drink alcohol?** ❑ Yes ❑ No	**Do you use street/recreational drugs?** ❑ Yes ❑ No
If Yes: How many packs a day? _____ How many years? _____ ❑ Quit Date: _____	If Yes: How much? _____ How often? _____ ❑ Quit Date: _____ ❑ In a recovery program?	If Yes: What? _____ How often? _____ ❑ Quit Date: _____ ❑ In a recovery program?

Family History

Mother	Father
Living ❑ Yes ❑ No If No Age @ death _____	Living ❑ Yes ❑ No If No Age @ death _____
Medical Conditions _____ _____ _____ _____ _____ _____	Medical Conditions _____ _____ _____ _____ _____ _____

Do you have a family history of:

❑ Yes ❑ No Osteoporosis If Yes, Who: _____
❑ Yes ❑ No Rheumatoid Arthritis If Yes, Who: _____
❑ Yes ❑ No Osteoarthritis If Yes, Who: _____
❑ Yes ❑ No Gout If Yes, Who: _____
❑ Yes ❑ No Other Connective Tissue Disease

If Yes, What: _____ Who: _____

Medical History

Referring Physician: _____

Reason for Visit: _____

Please list your medical conditions:

_____ _____

_____ _____

Hospitalizations & Surgeries - Please list all

Year	Operation / Illness	Year	Operation / Illness
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

Allergies - Please list any allergies to medications, foods, x-ray dyes, environmental items, adhesive tapes. *Example: Penicillin causes rash, eggs cause hives, Pollen causes sneezing.*

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications (list all medications you are now taking or have taken in the last 2 weeks)

Name of Medication	MG / Times per day	Reason for taking	How long?
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Have you recently had any of the following?

GENERAL		GASTROINTESINAL	
Fatigue	❒ Yes ❒ No	Loss of Appetite	❒ Yes ❒ No
Marked weight change	❒ Yes ❒ No	Difficulty Swallowing	❒ Yes ❒ No
Night Sweats	❒ Yes ❒ No	Heartburn	❒ Yes ❒ No
Persistent fever	❒ Yes ❒ No	Nausea or Vomiting	❒ Yes ❒ No
Sensitivity to cold	❒ Yes ❒ No	Diarrhea	❒ Yes ❒ No
Blood Clots legs/lungs	❒ Yes ❒ No	Stomach Ulcer	❒ Yes ❒ No

SKIN

Skin Rash	❒ Yes ❒ No
Hair loss / thinning	❒ Yes ❒ No
Change in nails	❒ Yes ❒ No
Reaction to sun	❒ Yes ❒ No
Psoriasis	❒ Yes ❒ No
Tightening of skin	❒ Yes ❒ No
Color changes to fingers	❒ Yes ❒ No

EYES

Vision Changes	❒ Yes ❒ No
Eye pain	❒ Yes ❒ No
Red eyes	❒ Yes ❒ No
Dry eyes	❒ Yes ❒ No

EARS

Loss of hearing	❒ Yes ❒ No
Ringing in ears	❒ Yes ❒ No

NOSE

Frequent nose bleeds	❒ Yes ❒ No
Persistent congestion	❒ Yes ❒ No

MOUTH

Mouth sores	❒ Yes ❒ No
Pain with chewing	❒ Yes ❒ No
Dry mouth	❒ Yes ❒ No

CARDIO-RESPIRATORY SYSTEM

Persistent Cough	❒ Yes ❒ No
Pain on breathing	❒ Yes ❒ No
Shortness of breath	❒ Yes ❒ No
Heart murmur	❒ Yes ❒ No
Chest pain	❒ Yes ❒ No

ENDOCRINE

Diabetes	❒ Yes ❒ No
Thyroid Disease	❒ Yes ❒ No

NERVOUS SYSTEM

Chronic Headache	❒ Yes ❒ No
Memory loss	❒ Yes ❒ No
Seizures	❒ Yes ❒ No
Numbness Tingling	❒ Yes ❒ No
Weakness / paralysis	❒ Yes ❒ No

GENITOURINARY

Blood in urine	❒ Yes ❒ No

OB-GYN

Number of pregnancies	_____
Number of miscarriages	_____
Hysterectomy	❒ Yes ❒ No
Hormone replacement	❒ Yes ❒ No

OSTEOPOROSIS

Had kidney stones	❒ Yes ❒ No
Height loss	❒ Yes ❒ No
Used Prednisone	❒ Yes ❒ No
Had fractures	❒ Yes ❒ No
Had food tolerance	❒ Yes ❒ No
Do you take Vitamin D	❒ Yes ❒ No
If Yes, how many units per day?	_____

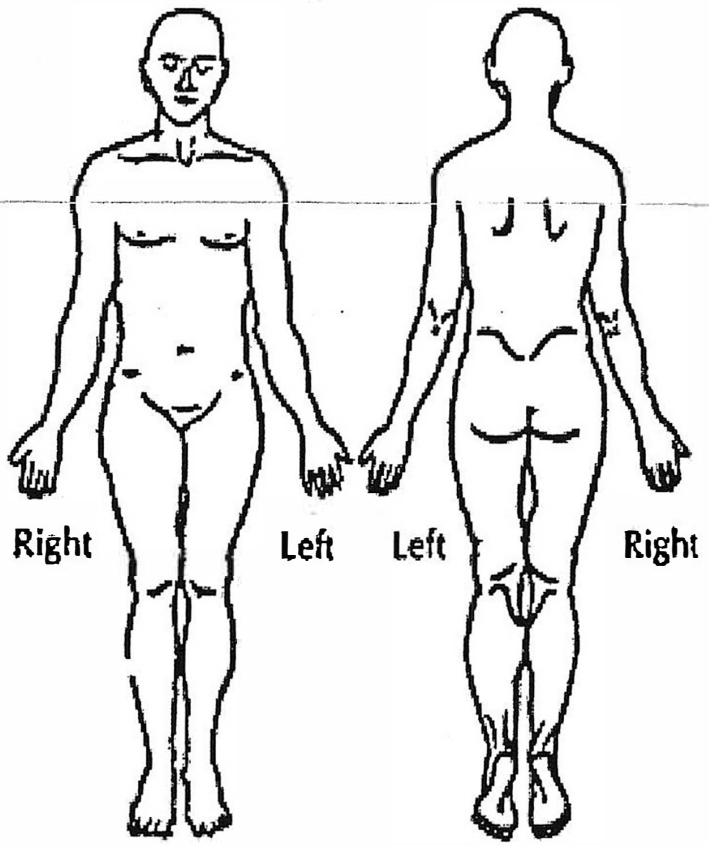
Activity – Please check the most appropriate answer

Vigorous Activity (Running, lifting heavy objects, etc)	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Moderate Activity (Pushing vacuum cleaner, playing golf, moving a table, etc.)	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Carrying / lifting groceries	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Climbing stairs	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Bending, kneeling, or stooping	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Bathing or dressing self	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Writing	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Feeding self, cutlery	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Getting out of a hair, car	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Walking one block	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all
Walking one mile	❒ Yes Limited A lot	❒ Yes Limited a little	❒ No Not limited at all

Where Do You Have Pain?

Please Mark Areas Below

PAIN **(X)** SWELLING **(+)** STIFFNESS **(-)**



Where do you have pain? _____

How often? _____ For how long? _____

What relieves the pain? _____

What causes or increases the pain? _____

Do you have swelling in your joints? _____

Do you have morning stiffness? ❒ Yes ❒ No If Yes, for how long? _____

What time of day is the worst for your symptoms? _____

Signature of Reviewing Physician: _____ Date: _____