PAST MEDICATIONS 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 comments in the spaces provided.

Drug Names/Dosages	Length of time	Please check: Helped? A lot	Some	Not At All	Reactions
Nonsteroidal Anti Inflammatory Drugs (NSAIDS)		☐	☐	☐	

Circle any you have taken in the past:

Nsaid (ibuprofen), Arthotec (diclofenac +Misoprostol), Aspirin (including coated aspirin), Celebrex (celecoxib), Clinoril (sulindac), Daypro (oxoprozin), Disalcid (salsalate), Dolobid (diflunisal), Feldene (piroxicam), Indocin (indomethacin), Lodine (etodolac), Meclomen (meclofenamate), Motrin/Rufen (ibuprofen), Nalfan (fenoprofen), Naprosyn (naproxen), Oravail (ketoprofen), Tolectin (Tolmetin), Trilisate (choline magnesium trisalicylate), Vioxx (rolecoxib), Voltaren (diclofenac)

Drug Names/Dosages	Length of time	A lot	Some	Not At All	Reactions
..... RELIEVERS					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs)	(DMARDS)	☐	☐	☐	
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Steroid/Shots (Myochrysine or Solganal)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Osteoporosis Medications		☐	☐	☐	
Estrogen (Premarin, etc)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etigronate (Digronel)		☐	☐	☐	
Roloxifene/Evista		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin Injection or Nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications		☐	☐	☐	
Probenecid (Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiluoronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc Injections		☐	☐	☐	
Herbal or Nutritional Supplements					
Please list supplements:					

MEDICATIONS

Drug allergries; ☐ No ☐ Yes To what? ____________________

Type of reaction: ____________________

PRESENT MEDICATIONS (List any medications you are taking. Include Such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & 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.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
11.			☐	☐	☐
12.			☐	☐	☐
13.			☐	☐	☐
14.			☐	☐	☐
15.			☐	☐	☐
16.			☐	☐	☐
17.			☐	☐	☐
18.			☐	☐	☐
19.			☐	☐	☐
20.			☐	☐	☐

Review of Systems

Date of last chest x-ray ___/___/___ Date of last Tuberculosis Test ___/___/___

Have you ever had a bone densitometry (bone density or DEXA scan)? Date ___/___/___

Date of last eye exam ___/___/___ Date of last flu shot ___/___/___

Date of last pneumonia vaccine ___/___/___

Have you ever had a colonoscopy? Yes No If yes, when? ___/___/___ And why did you have it? ____________________

Did you have any x-rays of your joints? Yes No If yes, when? ___/___/___ And what joints or areas were x-rayed? ____________________

And if yes, please bring those x-ray films with you.

Date of last laboratory or blood work ___/___/___ Could you bring a copy with you?

And why was it done? ____________________

Please circle all that appy to you: History of osteoporosis, wrist or hip fracture in your family, history of wrist, hip fracture or osteoporosis in yourself. Thyroid disease. Parathyroid disease. Kidney stones. Renal insufficiency. Malabsorption/Celiac disease. Endometriosis. Tooth loss.

Have you ever been on any of the following medications? Oral contraceptives. Hormone/Estrogen replacement therapy. Anticonvulsants. Thyroid hormones. Antacids containing aluminum.

Females only: Dates of first and last menstrual period. First ___/___/___ Last ___/___/___

Date of last mammogram ___/___/___ Date of last Pap Smear ___/___/___

Number of pregnancies? ________ Number of miscarriages? ________

Patient's Name ____________________ Date ____________________ Physician Initials ________

Do you drink caffinated beverages
Cups/glasses per day? ____________

Do you smoke? ☐ Yes ☐ No ☐ Past - How long ago? ____

Do you drink alcohol? ☐ Yes ☐ No Number per week ____

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

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

Do you exercise regularly? ☐ Yes ☐ No
Type ____________
Amaual per week ____________

How many hours of sleep do you get at night? ____________

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

Do you wake up feeling rested? ☐ Yes ☐ No

Do you have or have you had?

☐ Cancer	☐ Heart Problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Stomach Ulcers	☐ Nervous Breakdown	☐ Rheumatic Fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney Disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list) ____________

Natural or Alternative Therapies (chiropracty, magnets, massage, over - the - counter preparations, etc.)

____

Previous Operations

	Type	Year	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ☐ Yes ☐ No If yes, describe: ____________

Any other serious injuries? ☐ Yes ☐ No If yes, describe: ____________

Any hospitalizations? ____________

Occupation: ____________ Marital History ____________

Family History:

	IF LIVING		IF DECEASED	
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings ____ Number living ____ Number deceased ____

Number of children ____ Number living ____ Number deceased ____ List ages of each ____________

Health of children: ____________

Do you know of any blood relative who has or had: (Check and give relationship)

☐ cancer ____	☐ Heart Disease ____	☐ Rheumatic Fever ____	☐ Tuberculosis ____
☐ Leukemia ____	☐ High Blood Pressure ____	☐ Epilepsy ____	☐ Diabetes ____
☐ Stroke ____	☐ Bleeding Tendency ____	☐ Asthma ____	☐ Goiter ____
☐ Colitis ____	☐ Alcoholism ____	☐ Psoriasis ____	☐ Rheumatoid Arthritis ____
☐ Lupus ____	☐ Scleroderma ____	☐ Any connective tissue disorder ____	

Patient's Name ____________ DOB ________ Date ________ Physician's Initials ________

1. Location of the problem #2: ____________________

2. On a Scale of 1 - 10, with 10 being the most severe, circle the number that best describes the problem.
1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem?
2 days ago 2 weeks age 1 month ago 1 year ago 5 years ago Other: ____________________

4. How long does the problem last? 5-15 minutes 16-30 minutes 31-59 minutes 1-2 hours Always there
other: ____________________

5. When is the problem worse? No relation to any specific time of day or night Morning Noon Afternoon
Nighttime Other: ____________________

6. Does anything make the problem worse? Yes No If yes, please explain.
Moving around Walking Standing Up Lying on my side Sitting Driving Other: ____________________

7. Does anything helps or makes the problem better? Yes No If yes, please explain.
____

8. Is anything else occurring at the same time? Yes No If yes, please explain.
Nausea Rash Headaches Numbness Tingling Swelling Stiffness Fever Other: ____________________

9. Is the problem constant or variable? Dull then Sharp Very Sharp then leaves Dull then Throbbing Constant
Other: ____________________

10. Does the problem interfere with your normal functions? Yes No If yes, please explain. ____________________

For Physician Use Only

H/O

Dx ed With
Initial Sx
Tx ed With

____ RP (W,B,R---H,F) With Rewarming NI in ____mins/hrs ____ Ulcers ____ Pit Scars ____ Gangr.
____ Sicca Sx ____ Eyes, ____ E. Drps/Art Trs. ____ Mouth, ____ Art Sal. ____ Dental D/Gum D ____ Allrg/DM
____ Serosilis ____ Plrsy ____ Pericard ____ Periton ____ Pancr. ____ Elev. LFT's ____ Enlarg. Liv/Spln
____ Alv Inf/Fib ____ Rash ____________ Re. To Sun (B/W) ____ Itch ____ Durat ______
____ Ves. (clr/pus)/MP/P/M/Pat ____ Color ____________ P. Alopecia ____ Ps (Sclp/bdy/nls)
____ Photo-sensit ____ Ulcrs ____ P. Ulcers ____ Gen. Ulcers ____ Red Eye ____ (Conj./Sicca/Scler./Iritis/
________) ____ Urethritis/STD ____ F/C (U&D ____) ____ Lympad. (N/Ax/Grn/____)
____ HA(Ten./Sin/Clustr) ____, (Sev/Mld/Mod) ____ GN, Class ____________ Hematurea (Mic/Grs)
____ Proteinurea/Nephrotic/ ____________ Dec. WBCs(N/L/ ____) ____ Elv. WBCs(N/L/ ____)
____ Elev. Eos ________ Dec. PLT ________ AIHA Myositis ____ MNM ____ FT Drp ____ DVT./PE
____ Miscarr. ____ Dysphag. (Up/Low) ____ SZ/TIA/CVA/Psyc ____ Fatugure ____ Insomnia
____ Nonrest Sleep ____ Inter: D/C ____ N/V ____ Abdo. Pain relfd w BM ____ Bloat

Note: This is a confidential record and will be kept in your doctor's office. Information continued here will not be released to anyone without your authorization to do so.

You have to fill out this form on your appointment date before you see Dr. Aqueel Kouser.

Today's Date: ___/___/___ Last Name: ______________________ First Name: ______________________ MI: ____
Social Security No.: ___-___-____ Date of Birth: ___/___/___ Age: __________
Martial Status: ______________ Occupation: ______________ Who referred you here? ______________
Date of Last Physician Exam: ___/___/___ Family Physician: ______________________

Chief Complaint: What is the main reason for your visit today? (Describe your problem) (Examples: pain in both hands, tingling in my right hand, pain all over, or rash on my face)

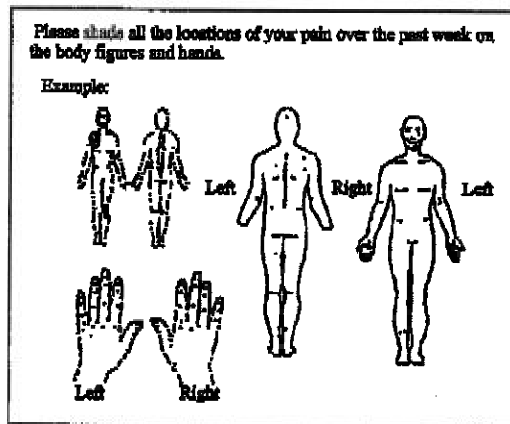
____

____

____

History of Present Illness: (Describe your problem in detail) Please answer each of the following 10 questions. If you have more than one problem, complete the back of this page and answer each of the 10 questions for ever problem. You may make copies of this form if you have more than 2 problems.

1. **Location of the problem:** (Circle)
All my joints All my muscles R/L Hand
R/L Elbow R/L Shoulder Neck Head
Upper/Middle/Lower Back R/L Hip
R/L Knee R/L Ankle R/L Foot R/L Calf
R/L Thigh Other: ______________



2. On a Scale of 1 - 10, with 10 being the most severe, circle the number that best describes the problem.
1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem?
2 days ago 2 weeks age 1 month ago 1 year ago 5 years ago Other: ______________

4. How long does the problem last? 5-15 minutes 16-30 minutes 31-59 minutes 1-2 hours Always there
other: ____

5. When is the problem worse? No relation to any specific time of day or night Morning Noon Afternoon
Nighttime Other: ____

6. Does anything make the problem worse? Yes No If yes, please explain.
Moving around Walking Standing Up Lying on my side Sitting Driving Other: ______________

7. Does anything helps or makes the problem better? Yes No If yes, please explain.

____

8. Is anything else occurring at the same time? Yes No If yes, please explain.
Nausea Rash Headaches Numbness Tingling Swelling Stiffness Fever Other: ______________

9. Is the problem constant or variable? Dull then Sharp Very Sharp then leaves Dull then Throbbing Constant
Other: ____

10. Does the problem interfere with your normal functions? Yes No If yes, please explain. ______________

____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Recent Weight Gain Y N
- Recent Weight Loss Y N
- Other:

Eyes
- Redness Y N
- Loss of Vision Y N
- Itching Eyes Y N
- Dry Eyes Y N
- Blurred Vision Y N
- Other:

Ear/Nose/Mouth/Throat
- Loss of Hearing Y N
- Ringing in Ears Y N
- Nose Bleeds Y N
- Loss of Smell Y N
- Dry Nose Y N
- Runny Nose Y N
- Bleeding Gums Y N
- Sores in Mouth Y N
- Dry Mouth Y N
- Frequent Sore Throat Y N
- Hoarseness Y N
- Other:

Allergic/ Immunologic
- Frequent sneezing Y N
- Drug Allergies Y N
- Increased susceptibility to infections Y N
- Other:

Gastrointestional
- Nausea Y N
- Vomiting of Blood Y N
- Black Stools Y N
- Stomach pain relieved by food Y N
- Constipation Y N
- Diarrhea Y N
- Bloating Y N
- Indigestion Y N
- Heartburn Y N
- Other:

Neurological
- Headaches Y N
- Memory loss Y N
- Dizziness Y N
- Loss of Consciousness Y N
- Numbness/Tingling Y N
- Other:

Psychiatric
- Are generally satisfied with your life? Y N
- Depression Y N
- Anxiety Y N
- Have you considered suicide? Y N
- Other:

Endocrine
- Excessive Thirst Y N
- Tired/Sluggish Y N
- Too hot/cold Y N
- Other:

Integumentary (Skin/Breast)
- Easy Bruising Y N
- Persistent Itch Y N
- Dry Skin Y N
- Color changes of hands/feet in the cold Y N
- Boils Y N
- Sun Allergy Y N
- Rash Y N
- Hair Loss Y N
- Other:

Genitourinary
- Painful Urination Y N
- Urinary Retention Y N
- Blood in Urine Y N
- Genital Rash/Ulcers Y N
- Sexual Difficulties Y N
- Vaginal Dryness Y N
- Other:

Hematologic/Lymphatic
- Swollen Glands Y N
- Tender Glands Y N
- Blood Transfusion Y N
- Anemia Y N
- Blood Clotting Problem Y N
- Other:

Cardiovascular
- High Blood Pressure Y N
- Varicose Veins Y N
- Swollen legs at night Y N
- Heart Murmurs Y N
- Chest Pain Y N
- Other:

Respiratory
- Shortness of Breath Y N
- Wheezing Y N
- Coughing Y N
- Difficulty breathing at night Y N
- Other:

Musculoskeletal
- Joint Pain Y N
- Joint Swelling Y N
- Morning Stiffness Y N
- Stiffness After Sitting Y N
- Muscle Weakness Y N
- Muscle Tenderness Y N
- Neck Pain Y N
- Back Pain Y N
- Other:

For Physician use only

Patient Name ______________________ Date ___/___/___ Physician Initials: __________