Rheumatology Apppointment

Thank you for making an appointment with Dr. Portnoff and the Rheumatology Department at The Portland Clinic. We look forward to meeting you.

If you would please take the time to fill out the Health History Form (attached) and arrive with the completed form to your appointment 30 minutes early so that we have the appropriate amount of time to check you in. Please also bring any pertinent records with you.

If you have any questions, don't hesitate to contact us at 503-221-0161 X2330.

Thank you.

Dr. Portnoff and the Rheumatology Staff

THE Portland Clinic LLP
Physicians & Surgeons®
We specialize in you.

PATIENT LABEL

Rheumatology: Health History

Check-in time _____ DT _____ BVT _____ STH _____

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment _____ Birthplace:_____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY STATE ZIP) Telephone: Home (____) _____
Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses_____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms:

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

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

_____

_____

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

_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

(continued)

OVER THE LAST MONTH HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Constitutional
- ❑ Recent weight gain
  Amount _____
- ❑ Recent weight loss
  Amount _____
- ❑ Fatigue
- ❑ Drenching night sweats
- ❑ Fever

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Dryness of mouth
- ❑ Frequent sore throat
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____
Periods regular: ❑ Yes ❑ No
How many days apart? _____
Date of last period: ___/____/____
Date of last pap: _____/____/____
Bleeding after menopause: ❑ Yes ❑ No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal
- ❑ Morning stiffness
  Lasting how long?
  _____ minutes _____ hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in last 6 mos.
  _____
  _____
  _____
  _____
  _____

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Tightness
- ❑ Nodules/bumps
- ❑Hair loss
- ❑ Purple or white color changes in hands and feet with cold exposure

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Numbness in hands or feet
- ❑ Memory loss

Psychiatric
- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep due to pain
- ❑ **Endocrine**
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/ when _____

(continued)

PATIENT LABEL

SOCIAL HISTORY

Do you drink caffeintated beverages? ❑ Yes ❑ No

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 _____

Amount 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

PAST MEDICAL HISTORY

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

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ 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 (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

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: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at 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 _____	

(continued)

MEDICATIONS

Drug allergies? ❑ 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.			❑	❑	❑

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 your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-steroidal Anti-Inflammatory drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past: Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)					
Codeine (Vicodin, Tylenol 3, Norco)					
Other:					
Other:					
Disease Modifying Antirheumatic Drugs (DMARDS)					
Remicade					
Rituxan					
Hydroxychloroquine (Plaquenil)					
Orencia					
Methotrexate (Rheumatrex)					
Azathioprine (Imuran)					
Sulfasalazine (Azulfidine)					
Cyclophosphamide (Cytoxan)					
Cyclosporine A (Sandimmune or Neoral)					
Etanercept (Enbrel, Humira, Simponi, or Cimzia)					
Infliximab (Remicade)					
Actemra					
Other:					
Other:					

(continued)

PATIENT LABEL

PAST MEDICATIONS Continued

Osteoporosis Medications					
Alendronate (Fosamax)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Reclast (Zolendronic Acid)		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications		❑	❑	❑	
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Febuxostat (Uloric)		❑	❑	❑	
Other:		❑	❑	❑	
Others		❑	❑	❑	
Arimidex, or Femara		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

_____

(continued)

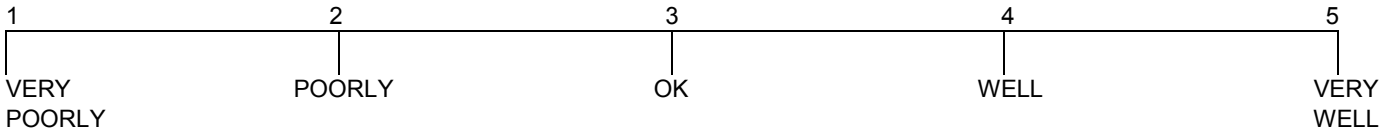
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do?_____

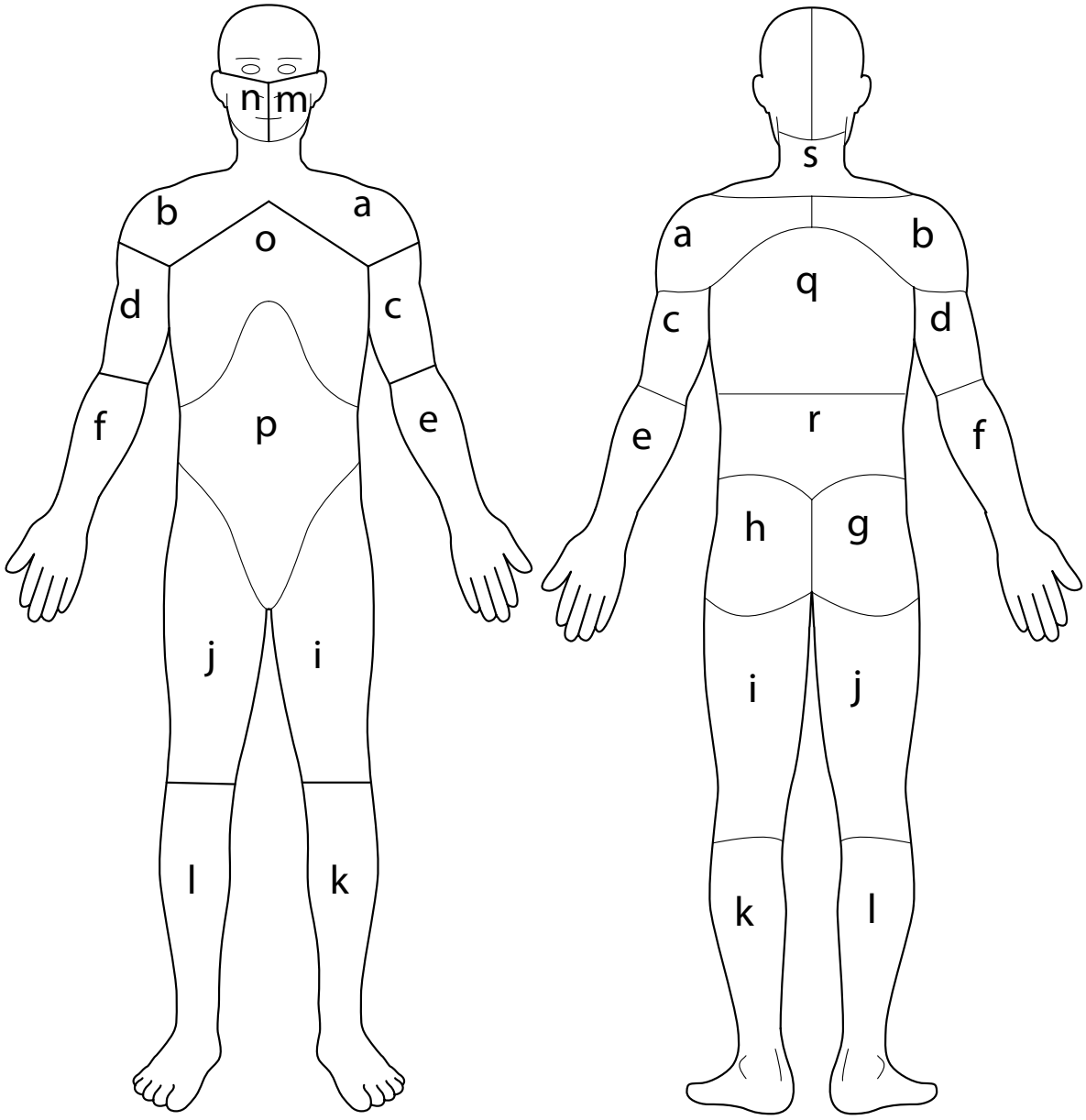
Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

(continued)

1 . On the diagram, circle all of the areas (letters) of pain over the ***LAST WEEK***?



Guide

a. Shoulder girdle, left
b. Shouler girdle, right
c. Upper arm, left
d. Upper arm, right
e. Lower arm, left
f. Lower arm, right
g. Hip (buttock, trochanter), left
h. Hip (buttock, trochanter), right
i. Upper leg, left
j. Upper leg, right
k. Lower leg, left
l. Lower leg, right
m. Jaw, left
n. Jaw, right
o. Chest
p. Abdomen
q. Upper back
r. Lower back
s. Neck

(continued)

Over the **PAST WEEK,** how **SEVERE** was your **FATIGUE**?
0 = no problem
1 = slight or mild problems, generally mild or intermittent
2 = moderate, considerable problems, often present and/or at moderate level
3 = severe: pervasive, continuous, life-disturbing problems

Over the **PAST WEEK,** how **SEVERE** did your **WAKING FEELING UNREFRESHED**?
0 = no problem
1 = slight or mild problems, generally mild or intermittent
2 = moderate, considerable problems, often present and/or at moderate level
3 = severe: pervasive, continuous, life-disturbing problems

Over the **PAST WEEK,** how **SEVERE** were your **COGNITIVE SYMPTOMS**?
0 = no problem
1 = slight or mild problems, generally mild or intermittent
2 = moderate, considerable problems, often present and/or at moderate level
3 = severe: pervasive, continuous, life-disturbing problems

Considering **SOMATIC SYMPTOMS** in general, indicate whether the patient has:*
0 = no symptoms
1= few symptoms
2 = a moderate number os symptoms
3 = a great deal of symptoms

* Somatic symptoms that might be considered: muscle pain, irritable bowel syndrome, fatigue/tiredness, thinking or remembering problem, muscle weakness, headache, pain/cramps in the abdomen, numbness/tingling, dizziness, insomnia, depression, constipation, pain in the upper abdomen, nausea, nervousness, chest pain, blurred vision, fever, diarrhea, dry mouth, itching, wheezing, Raynaud's phenomenon, hives/welts, ringing in ears, vomiting, heartburn, oral ulcers, loss of/change in taste, seizures, dry eyes, shortness of breath, loss of appetite, rash, sun sensitivity, hearing difficulties, easy bruising, hair loss, frequent urination, painful urination, and bladder spasms.