JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

4004957500-191

SJOGREN'S CENTER NEUROLOGY / RHEUMATOLOGY PATIENT HISTORY FORM

Date: ______/________/________

NAME: ____ Birth date: _____/______/_____
Last First M. I.

Age:__________ Sex: ❑ Female ❑ Male

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Significant other

Whom do we thank for referring you here? Physician Name:	Name of your primary care physician: Physician Name:
Physician Address:	Physician Address:
Phone:	Phone:
Fax:	Fax:

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:

Left Right Left

Left Right

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

What related 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 __________ Date ___________

(10/10)

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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)	❑Yes ❑No	❑Yes ❑No	→	______
Osteoarthritis	❑Yes ❑No	❑Yes ❑No	→	______
Rheumatoid arthritis	❑Yes ❑No	❑Yes ❑No	→	______
Gout	❑Yes ❑No	❑Yes ❑No	→	______
Lupus or "SLE"	❑Yes ❑No	❑Yes ❑No	→	______
Ankylosing spondylitis	❑Yes ❑No	❑Yes ❑No	→	______
Childhood arthritis	❑Yes ❑No	❑Yes ❑No	→	______
Sjogren's syndrome	❑Yes ❑No	❑Yes ❑No	→	______
Osteoporosis	❑Yes ❑No	❑Yes ❑No	→	______
Psoriasis/psoriatic arthritis	❑Yes ❑No	❑Yes ❑No	→	______

PAST MEDICAL HISTORY

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

❑Yes ❑No Diabetes	❑Yes ❑No Heart murmur	❑Yes ❑No Crohn's disease
❑Yes ❑No High blood pressure	❑Yes ❑No Pneumonia	❑Yes ❑No Colitis
❑Yes ❑No High cholesterol	❑Yes ❑No Pulmonary embolism	❑Yes ❑No Anemia
❑Yes ❑No Hypothyroidism	❑Yes ❑No Asthma	❑Yes ❑No Jaundice
❑Yes ❑No Goiter	❑Yes ❑No Emphysema	❑Yes ❑No Hepatitis
❑Yes ❑No Cancer (type)______	❑Yes ❑No Stroke	❑Yes ❑No Stomach or peptic ulcer
❑Yes ❑No Leukemia	❑Yes ❑No Epilepsy (seizures)	❑Yes ❑No Rheumatic Fever
❑Yes ❑No Psoriasis	❑Yes ❑No Cataracts	❑Yes ❑No Tuberculosis
❑Yes ❑No Angina	❑Yes ❑No Kidney disease	❑Yes ❑No HIV/AIDS
❑Yes ❑No Heart problems	❑Yes ❑No Kidney stones	

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? ❑ No ❑ Yes ❑ In the past - How long ago? ______ How much: ______

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

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

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

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

Do you wake up feeling rested? ❑ No ❑ Yes

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ____________________

____

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: ____________________

SJOGREN'S SYMPTOMS

Have you had dry eye symptoms for 3 months or more? ❑ Yes ❑ No

Have you had a foreign body sensation in your eyes? ❑ Yes ❑ No

Do you use artificial tears more than 3 times per day? ❑ Yes ❑ No

Have you had dry mouth symptoms for 3 months or more? ❑ Yes ❑ No

Have you had recurrent or persistently swollen salivary glands? ❑ Yes ❑ No

Do you need liquids to swallow dry foods? ❑ Yes ❑ No

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SYSTEMS REVIEW: PLEASE CHECK OFF ANY SYMPTOMS THAT APPLY TO YOU NOW

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 ❑ Yes ❑ No; how much___
Recent weight loss ❑ Yes ❑ No; how much___
Fatigue ❑ Yes ❑ No
Weakness ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Night sweats ❑ Yes ❑ No

MUSCLE/JOINTS/BONES
Morning stiffness ❑ Yes ❑ No
Lasting how long Minutes Hours
Joint pain ❑ Yes ❑ No
Muscle weakness ❑ Yes ❑ No
Joint swelling ❑ Yes ❑ No
List joints affected in the last 6 months

EARS
Ringing in ears ❑ Yes ❑ No
Loss of hearing ❑ Yes ❑ No

EYES
Pain ❑ Yes ❑ No
Redness ❑ Yes ❑ No
Loss of vision ❑ Yes ❑ No
Double or blurred vision ❑ Yes ❑ No

MOUTH
Sore tongue ❑ Yes ❑ No
Bleeding gums ❑ Yes ❑ No
Sores in mouth ❑ Yes ❑ No
Loss of taste ❑ Yes ❑ No
Recent increase in tooth cavities ❑ Yes ❑ No

NOSE
Nosebleeds ❑ Yes ❑ No
Loss of smell ❑ Yes ❑ No

THROAT
Frequent sore throats ❑ Yes ❑ No
Hoarseness ❑ Yes ❑ No
Difficulty in swallowing ❑ Yes ❑ No
Pain in jaw while chewing ❑ Yes ❑ No

NECK
Swollen glands ❑ Yes ❑ No
Tender glands ❑ Yes ❑ No

HEART AND LUNGS
Pain in chest ❑ Yes ❑ No
Irregular heart beat ❑ Yes ❑ No
Sudden changes in heart beat ❑ Yes ❑ No
Shortness of breath ❑ Yes ❑ No
Difficulty in breathing at night ❑ Yes ❑ No
Swollen legs or feet ❑ Yes ❑ No
Cough ❑ Yes ❑ No
Coughing of blood ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No

STOMACH AND INTESTINES
Nausea ❑ Yes ❑ No
Heartburn ❑ Yes ❑ No
Stomach pain relieved by food ❑ Yes ❑ No
Vomiting of blood/"coffee grounds" ❑ Yes ❑ No
Yellow jaundice ❑ Yes ❑ No
Increasing constipation ❑ Yes ❑ No
Persistent diarrhea ❑ Yes ❑ No
Blood in stools ❑ Yes ❑ No
Black stools ❑ Yes ❑ No

KIDNEY/URINE/BLADDER
Difficult urination ❑ Yes ❑ No
Pain or burning on urination ❑ Yes ❑ No
Blood in urine ❑ Yes ❑ No
Cloudy, "smoky" urine ❑ Yes ❑ No
Pus in urine ❑ Yes ❑ No
Discharge from penis/vagina ❑ Yes ❑ No
Frequent urination ❑ Yes ❑ No
Getting up at night to pass urine ❑ Yes ❑ No
Vaginal dryness ❑ Yes ❑ No
Rash/ulcers ❑ Yes ❑ No
Sexual difficulties ❑ Yes ❑ No
Prostate trouble ❑ Yes ❑ No

BLOOD
Anemia ❑ Yes ❑ No
Bleeding tendency ❑ Yes ❑ No

SKIN
Easy bruising ❑ Yes ❑ No
Redness ❑ Yes ❑ No
Rash ❑ Yes ❑ No
Hives ❑ Yes ❑ No
Sun sensitive ❑ Yes ❑ No
Skin tightness ❑ Yes ❑ No
Nodules/bumps ❑ Yes ❑ No
Hair loss ❑ Yes ❑ No
Color changes of ❑ Yes ❑ No
hands or feet in the
cold (Raynaud's)

NERVOUS SYSTEM
Headaches ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No
Fainting or loss of consciousness ❑ Yes ❑ No
Numbness or tingling in hands/feet ❑ Yes ❑ No
Memory loss ❑ Yes ❑ No
Muscle weakness ❑ Yes ❑ No

PSYCHIATRIC
Depression ❑ Yes ❑ No
Excessive worries ❑ Yes ❑ No
Difficulty falling asleep ❑ Yes ❑ No
Difficulty staying asleep ❑ Yes ❑ No

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? _________

❑ *(for physician)* **All other systems reviewed and are negative**

Name of person completing this form: ____________________________________

Reviewed by: ______________________ M.D. ______________________ M.D. Date: ___________
Signature Printed

(10/10)