James E. Dowd, MD, PC
Board Certified Adult and Pediatric Rheumatologist
Board Certified Integrative Holistic Medicine

10484 Citation Drive, Suite 100
Brighton, MI 48116
Phone (810) 225-7553
Fax (810) 225-7558

New Patient History Form

Date of first appointment:_____/____/_____ Name: _____ Birthdate: _____
MONTH DA Y YEAR

Describe briefly your present symptoms: _____

_____

_____

Date symptoms began (approximate): _____

Have you seen another Rheumatologist or an orthopedic doctor for these symptoms? ☐ No ☐ Yes, if yes, name:

_____

When was your last flu vaccine? _____

When was your last pneumonia vaccine? _____

When was your last TB test? _____

FAMILY HISTORY

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

- ❑ Alcoholism _____
- ❑ Anxiety/PTSD _____
- ❑ Depression_____
- ❑ Colitis _____
- ❑ Coronary Artery Disease_____
- ❑ Diabetes _____
- ❑ High blood pressure _____
- ❑ Psoriasis_____
- ❑ Inflammatory Bowel Disease _____
- ❑ Cancer (type)_____
- ❑ Gout_____
- ❑ Kidney Stones_____
- ❑ Thyroid Disease_____
- ❑ Chronic Renal Failure_____
- ❑ Tuberculosis_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

Have **YOU or a BLOOD RELATIVE** had any of the following? (please check if "yes")

Arthritis (unknown type): ❑ You ❑ Relative - relationship to you _____
Osteoarthritis: ❑ You ❑ Relative - relationship to you _____
Gout: ❑ You ❑ Relative - relationship to you _____
Childhood arthritis: ❑ You ❑ Relative - relationship to you _____
Lupus or "SLE": ❑ You ❑ Relative - relationship to you _____
Rheumatoid Arthritis: ❑ You ❑ Relative - relationship to you _____
Ankylosing Spondylitis: ❑ You ❑ Relative - relationship to you _____
Osteoporosis: ❑ You ❑ Relative - relationship to you _____

YOUR PAST MEDICAL HISTORY

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

- ❑ Abnormal Kidney Function
- ❑ Kidney stones
- ❑ Abnormal Liver Function
- ❑ Bladder Problems
- ❑ Blood clots, thrombi or emboli
- ❑ Bowel problems
- ❑ Cancer – type_____
- ❑ Congestive heart failure
- ❑ Coronary artery disease
- ❑ Coronary artery bypass
- ❑ Depression
- ❑ Diabetes: Type I_____ Type II _____
- ❑ Diverticulitis
- ❑ Fractures, type: _____
- ❑ Hypertension/High Blood Pressure
- ❑ Hysterectomy or Ovary Removal
- ❑ Lung disease / breathing problems
- ❑ Asthma
- ❑ Emphysema
- ❑ Thyroiditis
- ❑ Thyroid disease
- ❑ Colitis
- ❑ Psoriasis
- ❑ Tuberculosis
- ❑ Bad headaches
- ❑ Rheumatic Fever
- ❑ Goiter
- ❑ Abnormal Liver Function
- ❑ Anemia
- ❑ HIV/AIDS

Other significant illnesses not listed: _____

Previous Surgeries – please list previous surgeries you have had:

Type	*Year*	*Type*	*Year*
1.		4.	
2.		5.	
3.		6.	

MEDICATION

CURRENT MEDICATIONS (List all medications, vitamins and supplements you are taking. If needed, use the back of the sheet.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do you have any drug allergies: ❑ No ❑ Yes If yes, please list the medication and type of reaction, below

Medication:_____ Reaction:_____ Medication:_____ Reaction:_____

Medication:_____ Reaction:_____ Medication:_____ Reaction:_____

PAST MEDICATIONS

Try to remember which medications below you have tried and put a check next to those you remember. Write how long you were taking the medication (guess if needed) and why you stopped the medication. Be as accurate as you possibly can.

Pain Relievers:	How long did you take this medication?	Why did you stop taking this medication?
❑ Tylenol (acetaminophen)		
❑ Codeine (vicodin/hydrocodone/Tylenol 3)		
❑ Darvocet/Darvon (Propoxyphene)		
❑ Oxycodone		

Rheumatologic Medications:		
❑ Hydroxychloroquine (Plaquenil)		
❑ Azathioprine (Imuran)		
❑ Sulfasalazine (Azulfidine)		
❑ Methotrexate (Rheumatrex)		
❑ Enbrel		
❑ Humira		
❑ Remicade		
❑ Orencia – Infusion or Injection		
❑ Actemra – Infusion or Injection		
❑ Rituxan		
❑ Simponi		
❑ Simponi Aria		
❑ Cimzia		
❑ Cosentyx		
❑ Inflectra		
❑ Benlysta		
❑ Auranofin, gold pills (Ridaura)		
❑ Gold shots (Myochrysine or Solganol)		
❑ Cyclophosphamide (Cytoxan)		

Osteoporosis Medications:		
❑ Actonel (Risedronate)		
❑ Fosamax (Alendronate)		
❑ Prolia		
❑ Reclast (Zoledronic acid)		
❑ Estrogen (Premarin, etc.)		
❑ Etidronate (Didronel)		
❑ Raloxifene (Evista)		
❑ Calcitonin injection		

Gout Medications:		
❑ Probenecid (Benemid)		
❑ Colchicine		
❑ Allopurinol (Zyloprim/Lopurin)		

Others:		
❑ Cortisone/Prednisone		
❑ Hyalgan/Synvisc injections		
❑ Herbal or Nutritional Supplements		

Patient Name: _____ DOB: _____

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Circle all you have taken in the past		
Arthrotec (diclofenac + misoprostil)	Dolobid (diflunisal)	Nalfon (fenoprofen)
Aspirin (including coated aspirin)	Feldene (piroxicam)	Naprosyn (naproxen) Voltaren (diclofenac)
Celebrex (celecoxib)	Indocin (indomethacin)	Oruvail (ketoprofen)
Clinoril (sulindac)	Lodine (etodolac)	Tolectin (tolmetin)
Daypro (oxaprozin)	Meclomen (meclofenamate)	Trilisate (choline magnesium trisalicylate)
Disalcid (salsalate)	Motrin/Rufen (ibuprofen)	Vioxx (rofecoxib)

SOCIAL HISTORY

Alcohol Use: ❑ non-drinker ❑ occasional ❑ moderate ❑ heavy ❑ recently quit ❑ recovery

Tobacco Use: ❑ never smoker ❑ every day smoker ❑ some day smoker ❑ former smoker

Tobacco Exposure: ❑ none ❑ minimal ❑ frequent ❑ daily ❑ family smokes indoors ❑ family smokes outdoors only

Drug Use: ❑ none ❑ some ❑ daily ❑ quit ❑ prefer to discuss with provider

Highest Level of Education Completed: _____

Work / School Status: ❑ full-time ❑ part-time ❑ self-employed ❑ retired ❑ disabled ❑ unemployed

Occupation: _____

Exercise: ❑ no exercise ❑ occasionally ❑ regularly ❑ light ❑ moderate ❑ heavy

Living situation: ❑ alone ❑ spouse ❑ parents ❑ relatives ❑ domestic partner ❑ caregiver ❑ roommates

Number of children over age 18: _____

Number of children under age 18: _____

Pets (type/how many): _____

Please list activities you enjoy doing when you are feeling well: _____

_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

General
- ❑ Fatigue
- ❑ Fever
- ❑ Recent weight gain, amount_____
- ❑ Recent weight loss, amount_____

Integumentary (skin and/or breast)
- ❑ Hair loss
- ❑ Nail changes
- ❑ Itching of the skin
- ❑ Rash
- ❑ Skin color changes

Head-Eyes-Ears-Nose-Mouth
- ❑ Headache
- ❑ Eye pain
- ❑ Eye redness
- ❑ Visual Disturbances
- ❑ Loss of vision
- ❑ Glasses or contacts
- ❑ Ringing in ears
- ❑ Sores in mouth

Neck
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Swollen glands

Respiratory
- ❑ Chronic cough
- ❑ Recent cough
- ❑ Difficulty breathing

Cardiovascular
- ❑ Chest pain
- ❑ Swollen legs, feet or hands
- ❑ Irregular heart beat
- ❑ Shortness of breath

Gastrointestinal
- ❑ Abdominal pain
- ❑ Changes in bowel habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting

Genitourinary
- ❑ Difficulty emptying bladder
- ❑ Discharge from penis/vagina
- ❑ Pain or burning when urinating
- ❑ Increased frequency to urinate
- ❑ Blood in urine
- ❑ Increased urgency to urinate

Musculoskeletal
- ❑ Decreased Range of motion in joints (list joints) _____ _____
- ❑ Joint Pain (list joints) _____ _____
- ❑ Joint redness (list joints)_____ _____
- ❑ Joint stiffness (list joints) _____ _____
- ❑ Joint swelling (list joints) _____ _____ _____
- ❑ Muscle spasms or twitches
- ❑ Muscle cramps
- ❑ Muscle weakness
- ❑ Muscle pain or tenderness

Neurological System
- ❑ Dizziness
- ❑ Loss of coordination
- ❑ Numbness
- ❑ Burning or prickling
- ❑ Visual changes

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Inability to concentrate
- ❑ Difficulty staying asleep
- ❑ Difficulty falling asleep

Endocrine
- ❑ Appetite changes
- ❑ Cold intolerance
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Swollen glands

For Women Only:

Number of pregnancies: _____

Number of miscarriages: _____

Date of last period? _____