CAROLINA ARTHRITIS ASSOCIATES, P.A.
System Review Form

Patient's Name: _____

Date: _____ SS#: _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY:
At any time have you or a blood relative had any of the following? (Check if "yes.")

Yourself	**Relative/relationship**		**Yourself**	**Relative/relationship**	
_____	_____	Arthritis (type unknown)	_____	_____	Osteoarthritis
_____	_____	Rheumatoid Arthritis	_____	_____	Gout
_____	_____	Lupus or "SLE"	_____	_____	Ankylosing spondylitis
_____	_____	Childhood arthritis	_____	_____	Osteoporosis

Other arthritis conditions:

_____

Do you suffer from or have difficulty with any of the symptoms listed below?

Yes	No	**GENERAL**
☐	☐	Fatigue
☐	☐	Change in appetite
☐	☐	Weight loss
☐	☐	Allergies
☐	☐	Sleep problems
☐	☐	Tumor or cancer
☐	☐	Anemia
☐	☐	White blood cells
☐	☐	Low platelet count
Yes	No	**HEAD**
☐	☐	Decreased vision
☐	☐	Redness of eyes
☐	☐	Nasal discharge/bleeding
☐	☐	Mouth ulcers
☐	☐	Dry eyes
☐	☐	Dry mouth
☐	☐	Enlarged lymph nodes

Yes	No	**Skin**
☐	☐	Changes in skin color
☐	☐	Hives
☐	☐	Psoriasis
☐	☐	Skin tightening
Yes	No	**CARDIOPULMONARY**
☐	☐	High blood pressure
☐	☐	Cough
☐	☐	Chest pain
☐	☐	Asthma
☐	☐	Tuberculosis
☐	☐	Shortness of breath
☐	☐	Pleurisy
☐	☐	Leg swelling
☐	☐	History of heart attack
☐	☐	Rheumatic fever
☐	☐	Enlarged heart

Yes	No	**GI (cont'd)**
☐	☐	Jaundice
☐	☐	Hepatitis
☐	☐	Diarrhea or constipation
Yes	No	**NERVOUS SYS.**
☐	☐	Seizures
☐	☐	Numbness/tingling
☐	☐	Paralysis
☐	☐	Stroke
☐	☐	Altered memory/intellect
☐	☐	Emotional problems
Yes	No	**FEMALE**
☐	☐	Menstrual problems
☐	☐	Menopause _____
☐	☐	Discharge
☐	☐	No. of pregnancies ____
☐	☐	No. of miscarriages _____
☐	☐	Breast disorders
☐	☐	Difficulty with pregnancies

Patient's Name: _____

SSN: _____

Yes	No	**ENDOCRINE**
☐	☐	Thyroid disease
☐	☐	Excess thirst or hunger
☐	☐	Sudden weight change
☐	☐	Change in hair or skin
☐	☐	Change in sex drive
☐	☐	Sensitivity to heat
☐	☐	Sensitivity to cold

Yes	No	**SKIN**
☐	☐	Rash
☐	☐	Tumors
☐	☐	Sun sensitivity
☐	☐	Nodules
☐	☐	Chronic skin conditions
☐	☐	Hair loss

Yes	No	**GENITOURINARY**
☐	☐	Painful urination
☐	☐	Discharge from urethra
☐	☐	Kidney stones
☐	☐	Blood in urine
☐	☐	Penile rash
☐	☐	Venereal disease
☐	☐	Difficulty starting/stopping urine
☐	☐	Prostate problems

Yes	No	**GI SYSTEM**
☐	☐	Abdominal Pain
☐	☐	Vomiting of blood
☐	☐	Bloody or black stool
☐	☐	Ulcer disease

Yes	No	**FAMILY HISTORY**
☐	☐	Arthritis
☐	☐	Psoriasis
☐	☐	Gout
☐	☐	Kidney disease
☐	☐	Migraine
☐		Seizure disorder
☐	☐	Stroke
☐	☐	Hypertension
☐	☐	Heart disease
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Other _____

SURGICAL HISTORY (Please list all surgeries)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of last eye examination: _____

Date of last chest x-ray: _____

Date of last tuberculosis test: _____

Do you currently smoke cigarettes? _____

Have you ever smoked cigarettes? _____
If so, how long ago? _____

Do you drink alcohol? _____ If so, how much? _____

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Patient's Name: _____

SSN: _____

Date of last menstrual period: _____

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If so, please list: _____

Drug allergies to: _____ _____ _____ _____ _____

PLEASE LIST ANY MEDICATION THAT YOU ARE NOW TAKING. INCLUDE SUCH ITEMS AS ASPIRIN, VITAMINS, LAXATIVES, CALCIUM, ETC.)

Name of Drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

REMARKS

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