

Arthritis Program

After completing this patient history form, please email it back to VancouverMPAP@vch.ca

PATIENT HISTORY FORM

NAME: _____

What are your current concerns/problems with your arthritis or joint surgery? (List in order of importance)

- 1.
- 2.
- 3.

Do you have an active case with ICBC or Worksafe BC? yes **no**

MEDICAL HISTORY:

When did your arthritis symptoms begin (approximately)? _____

When were you diagnosed? _____

Please tick the appropriate box if any of the following apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoking/vaping |
| <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Seizures | <input type="checkbox"/> Breathing problems (e.g. asthma) |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological conditions |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Other: _____ |

FALL RISK:

Have you fallen in the last 3 months?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you ever feel unsteady when you stand or walk?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have to use the bathroom quickly or often?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> macular degeneration <input type="checkbox"/> blurred vision	
Do you feel confused or have trouble concentrating?	<input type="checkbox"/> yes <input type="checkbox"/> no

Please tick the appropriate box if you have seen any health professionals for your arthritis:

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Rheumatologist | <input type="checkbox"/> Occupational therapist | <input type="checkbox"/> None |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physiotherapist | |
| <input type="checkbox"/> Orthopaedic surgeon | <input type="checkbox"/> Other professionals (please list) | |

SURGERY: Have you had surgery for your arthritis or other major surgery? Yes No

Please list and date (ie. Left hip replacement 1988)

ARTHRITIS SURGERIES	YEAR	OTHER MAJOR SURGERIES	YEAR

Please turn over and complete other side of form

DIAGNOSTIC TESTS: (If yes, list area tested)

AREA

APPROX. YEAR

X-rays:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
CT Scan:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Bone Scan:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
MRI:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____
Other:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	_____

MEDICATIONS:

Current arthritis medications	Previous arthritis medications	Other current medications

DISEASE ACTIVITY:

Do your joints feel stiff in the mornings? Yes No How long does this usually last? _____

Do you have a problem with fatigue? Yes No

Have you recently lost or gained weight? How much? _____

ACTIVITY LEVEL:

On average, how many days a week do you do physical activity or exercise where your heart beats faster and your breathing is harder than normal (such as a brisk walk)? _____ days/week

On average, how many total minutes of physical activity/exercise do you do on those days? _____ mins

On average, how many awake hours in a day do you spend sitting or lying still (e.g., watching TV, using computer, reading) _____ hours/day

DAILY LIVING:

Living situation: House Apartment Alone with others _____

Work situation: full time part time retired not employed on disability leave

Are you having any difficulties in the following areas?

Self-care

- Dressing
- Bathing/showering
- Personal hygiene
- Eating
- Sleeping
- Other: _____

Home & community

- House work
- Yard/outdoor work
- Shopping/errands
- Transportation (e.g. driving, transit)
- Meal prep

Work & leisure

- Paid or unpaid work
- Caregiving (children/elders)
- Leisure & hobbies
- Walking
- Sexuality & intimacy

SELF-MANAGEMENT:

What do you do to help manage your arthritis pain?

- Medications Heat Cold Splints Brace/tape Insoles/footwear Relaxation/meditation
- Other: _____

Have you participated in any arthritis education classes? No Yes (in-person) Yes (online)

Please return completed form to your healthcare provider