Thomas Susko M.D., Inc.
2021 Santa Monica Blvd #200e
Santa Monica, CA 90404
Phone: (310) 829-5557
Fax: (310) 829-5554
Good Medicine Takes Time

Today's Date: _____

Name (First, middle initial, last): _____

Birthday (MM/DD/YYYY): _____ Birthplace: _____

Age: _____ Sex: _____ Maiden Name: _____

Address: _____

_____

Telephone number: Home: _____Work: _____ Okay to leave message: **Y** or **N**

Marital Status

Please circle: **Never Married** **Currently Married** **Divorced** **Separated** **Widowed** **Single**

Spouse/Significant Other:_____ Age:_____ Major Illnesses: _____

Education

Highest level of school attended: _____ College degree: _____

Occupation: _____ Number of hours per week worked: _____

Referred by (please circle): **Self** **Doctor** **Family** **Friend** **Other Health Professional**

Name of person that referred you: _____

Primary Care Physician: _____

Briefly describe your current symptoms:

_____
_____
_____
_____

Approximate date symptoms began: _____

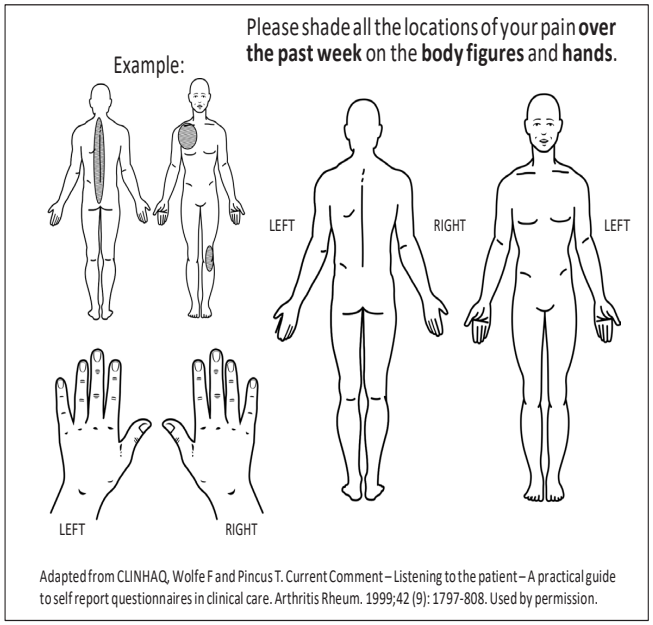
Diagnosis: _____

Previous treatment for this problem (please include physical therapy, surgery, and injections. Medications to be listed on another form):

_____
_____
_____

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

_____
_____



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

Physician Initials: _____

Rheumatologic (Arthritis) History At any time have you or a blood relative had any of the following?

Yourself		Relative Relationship	Yourself		Relative Relationship
	Arthritis (unk type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions:_____

Systems Review (Please check off which symptoms you are currently experiencing below)

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

Date of last mammogram: _____ Date of last eye exam: _____

Date of last chest x-ray: _____ Date of last Tuberculosis Test: _____

Date of last medical physical: _____ Date of last bone density scan: _____

Constitutional

- Recent weight gain
  Amount: _____
- Recent weight loss
  Amount: _____
- Fatigue
- Weakness
- Fever

Eyes

- Pain
- Redness
- Loss of Vision
- Double or blurred vision
- Dry eyes
- Itchy eyes
- Feels like something in eye

Endocrine

- Excessive thirst

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

Integumentary (skin and/or breasts)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitivity
- Skin tightness
- Nodules/bumps
- Hair loss
- Color changes in hands or feet in cold weather

Ears, Nose, Mouth, Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dry mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Psychiatric

- Excessive worry
- Anxiety
- Easily loses temper
- Depression
- Agitation
- Difficultly falling asleep
- Difficulty staying asleep

Physician Initials: _____

For Women Only:

- Age when periods began:
- Regular Periods? Y or N
- How many days apart: _____
- Date of last period: _____
- Date of last pap smear: ____
- Bleeding after menopause? Y or N
- Number of pregnancies: ___
- Number of miscarriages: ___

Musculoskeletal

- Morning Stiffness? Y or N

  Lasting how long?

  ____mins ____hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
  Please list affected joints in the past 6 months:
  _____
  _____
  _____
  _____

Cardiovascular

- Chest pain
- Irregular heartbeat
- Sudden changes in heartbeat
- High blood pressure
- Heart murmurs

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Genitourinary

- Difficult urinating
- Pain/burning during urination
- Blood in urine
- Cloudy/smoky urine
- Pus in urine
- Discharge from penis/vagina
- Urinating in the middle of the night
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

Respiratory

- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- Cough
- Coughing up blood
- Wheezing
- Asthma

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain in hands or feet
- Memory loss
- Night sweats

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeds easily
- Blood transfusion
  When: _____

Physician Initials: _____

Medications

Drug allergies: **YES** or **NO**

If yes, please list the names of the medication and the type of reaction:

_____

_____

_____

Past Medications

In the table below, to the best of your memory please write down any and all medications that you have taken for the condition that you are seeing the doctor today.

Name of medication **Ex: type of pain relievers, NSAIDs.**	**Dose/strength**	**Frequency** **Ex: once a day? Twice a day? Injection?**	**When did you START this medication?**	**When did you STOP this medication?**	**Did it help?**

Physician Initials: _____

Below is a list of common Disease Modifying Antirheumatic Drugs (DMArDS). If you have taken any of the medications listed below, please complete the chart to the best of your memory.

DMArDS	**Dose/Strength**	**Frequency Ex: once a day? Twice a day?**	**When did you START this medication?**	**When did you STOP this medication?**	**Did it help?**
Certolizumab					
Golimumab					
Hydroxychloroquine					
Penicillamine					
Methotrexate					
Azathioprine					
Sulfasalazine					
Quinacrine					
Cyclophosphamide					
Cyclosporine A					
Etanercept					
Infliximab					
Tocilizumab					
Other:					
Other:					

Additional comments/notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Physician Initials: _____

Social History

Do you drink caffeinated beverages? **Yes** or **No**

Cups/glasses per day: _____

Do you smoke cigarettes currently? **Yes** or **No**

Did you smoke cigarettes in the past? **Yes** or **No** How long ago: _____

Do you drink alcohol? **Yes** or **No** Amount of drinks per week: _____

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

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

If yes, please list type: _____

Do you exercise regularly? **Yes** or **No**

Type of exercise: _____

Amount of exercise per week: _____

How many hours of sleep do you get each night? _____

Do you get enough sleep at night? **Yes** or **No**

Do you wake up feeling rested? **Yes** or **No**

Past Medical History

Do you currently have, or have ever had in the past the following:

- o Cancer
- o Goiter
- o Cataracts
- o Nervous Breakdown
- o Bad Headaches
- o Kidney Disease
- o Anemia
- o Emphysema
- o Heart Problems
- o Leukemia
- o Diabetes
- o Stomach Ulcers
- o Jaundice
- o Pneumonia
- o HIV/AIDS
- o Glaucoma
- o Asthma
- o Stroke
- o Epilepsy
- o Rheumatic Fever
- o Colitis
- o Psoriasis
- o High Blood Pressure
- o Tuberculosis

Physician Initials: _____

Other significant illness (please list):

_____

_____

_____

Natural or Alternative Therapies (for example: Chiropractic, magnets, massage, acupuncture/acupressure, over-the-counter devices, etc):

_____

_____

_____

Previous Surgeries

Type of Surgery	**Year**	**Reason**

Any previous fractures? **Yes** or **No**

Please describe: _____

_____

_____

Any other serious injuries? **Yes** or **No**

Please describe: _____

_____

_____

Physician Initials: _____

Family History

	If Living		If Deceased	
	Age	**Health**	**Age at death**	**Cause of death**
Father				
Mother				

Number of siblings: _____ Number of siblings living: _____ Number of siblings deceased: _____

Number of children: _____ Number of children living: _____ Number of children deceased: _____

Please list the ages of your children: _____

_____

Health of your children: _____

_____

_____

Do you know any blood relative who has or had any of the following conditions:

Condition	**Relationship**
Cancer	
Tuberculosis	
Diabetes	
Goiter	
Heart Disease	
Leukemia	
Stroke	
Colitis	
Rheumatic Fever	
High Blood Pressure	
Bleeding issues	
Alcoholism	
Epilepsy	
Asthma	
Psoriasis	

Physician Initials: _____