Vancouver Coastal Health
Promoting wellness. Ensuring care.
Arthritis Program

Clear Form

DATE: ____________________

CARE CARD NUMBER: ____________________

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:

☐ High or low blood pressure
☐ Heart conditions
☐ Osteoporosis
☐ Stress
☐ Cancer
☐ Seizures
☐ Diabetes
☐ Anxiety/depression
☐ Smoking/vaping
☐ Breathing problems (e.g. asthma)
☐ Neurological conditions
☐ Other: ____________________________

FALL RISK:

Have you fallen in the last 3 months?	☐yes ☐no
Do you ever feel unsteady when you stand or walk?	☐yes ☐no
Do you have to use the bathroom quickly or often?	☐yes ☐no
Do you have ☐cataracts ☐glaucoma ☐macular degeneration ☐blurred vision	
Do you feel confused or have trouble concentrating?	☐yes ☐no

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

☐ Rheumatologist
☐ Neurologist
☐ Orthopaedic surgeon
☐ Occupational therapist
☐ Physiotherapist
☐ Other professionals (please list)
☐ None

____

____

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

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DIAGNOSTIC TESTS: (If yes, list area tested) **AREA** **APPROX. YEAR**

			AREA	APPROX. YEAR
X-rays:	☐ No	☐ Yes	______	______
CT Scan:	☐ No	☐ Yes	______	______
Bone Scan:	☐ No	☐ Yes	______	______
MRI:	☐ No	☐ Yes	______	______
Other:	☐ No	☐ 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	**Home & community**	**Work & leisure**
☐ Dressing	☐ House work	☐ Paid or unpaid work
☐ Bathing/showering	☐ Yard/outdoor work	☐ Caregiving (children/elders)
☐ Personal hygiene	☐ Shopping/errands	☐ Leisure & hobbies
☐ Eating	☐ Transportation (e.g. driving, transit)	☐ Walking
☐ Sleeping	☐ Meal prep	☐ Sexuality & intimacy
☐ Other: ______________		

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

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