RHEUMATOLOGY

Patient's Name: ___________________________________ ___________________

Date of first appointment: ____/_____/_______

Date of birth: ____/____/_______ Age: _____________ Sex: _____________

Home phone: (______)________________ Cell phone: (______)________________

Work phone: (______)_________________

May we leave a message on your phone listed above? Yes □ No □

REASON FOR THIS APPOINTMENT:

____

Describe symptoms:

____

____

____

When approximately did these symptoms start?

____

Have you seen others for this problem (including other rheumatologists)? If yes, list below.

Name: ____

Name: ____

PREVIOUS TREATMENT OF RHEUMATOLOGIC ISSUES: Check box if yes and list below.

- Rheumatologic Medications: ____

____

- Other Treatments: ____

____

____

DRUG ALLERGIES: Please list any medicines you have had a reaction to.

Name of Medication	Reaction Type

LIST OF MEDICATIONS: Please list all current medications you are taking. If more space in needed, please bring complete list on a separate piece of paper.

Medication Name	Dose (How much)	Frequency (How often)
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________
______________________________	____________________	____________________

SURGERIES:

Type of Surgery	Year	Additional comments:

MEDICAL CONDITIONS: Check if YOU have been diagnosed with or have the following:

☐ Allergies	☐ Crohn's disease	☐ Headaches	☐ Miscarriage
☐ Anemia	☐ Dentures	☐ Hearing aids	☐ Osteoarthritis
☐ Anxiety	☐ Depression	☐ Heart murmur	☐ Osteoporosis
☐ Arthritis	☐ Diabetes Type 1	☐ Heart problems	☐ Peptic ulcer
☐ Asthma	☐ Diabetes Type II	☐ Hepatitis	☐ Psoriasis
☐ Blood clots	☐ Eye inflammation	☐ High blood pressure	☐ Rashes / skin problems
☐ Cancer	☐ Fibromyalgia	☐ High cholesterol	☐ Seizures
☐ Chicken Pox	☐ GERD	☐ Hypothyroidism	☐ Shingles
☐ Chronic lung disease	☐ Gout	☐ Kidney disease	☐ Ulcerative colitis

Additional or comments:

____

____

Any previous fractures? No ☐ Yes ☐ Describe________________________________

Any serious injuries? No ☐ Yes ☐ Describe__________________________________

PERSONAL HISTORY:

Do you drink caffeine in the form of coffee/tea/soda? Yes: ☐ No: ☐

If yes, how many cups (average) per day? _____________

Do you drink alcohol? Yes: ☐ No: ☐

If yes, how many drinks per week?__________ Drink(s) of choice_________________

Do you use street drugs or opioids? Yes: □ No: □

If yes, how often? _________________ List drug name(s)_______________________

Have you or do you use tobacco products? Yes: □ No: □ Quit? □ Quit Date:_______

Cigarettes_________________ per day Age started________ for________ years

Cigars____________________ per day Age started________ for_______ years

E-cigarettes _____________ cartridges per day Age started______for______years

Smokeless tobacco? Yes: □ No: □ If currently using, any interest in quitting?_____

Occupation:______________________________

Average number of hours worked per week?_________ Retired?_______

FAMILY HISTORY: Has anyone in your family (parents, grandparents, brothers, sisters, aunts, uncles, children) had any of the following conditions (to the best of your knowledge)?

	Family relationship:
Osteoarthritis	
Rheumatoid arthritis	
Spondylarthritis	
Ankylosing spondylitis	
Psoriatic arthritis	
Childhood (juvenile) arthritis	
Gout	
Sjogren's	
Lupus	
Crohn's disease	
Ulcerative colitis	
Celiac disease	
Psoriasis	
Hashimoto's Thyroiditis	

GENERAL:

□ Chills
□ Fevers
□ Drenching night sweats
□ Recent weight loss

EYES:
□ Blurred vision
□ Double vision
□ Pain in eyes
□ Sensitivity to light
□ Redness
□ Loss of vision
□ Dryness

ALLERGY:
□ Environmental allergies
□ HIV exposure
□ Hives
□ Persistent infections

EARS/NOSE/ THROAT:
□ Sores in mouth
□ Sores in nose
□ Sore tongue with talking
□ Dry mouth
□ Sudden hearing loss
□ Nose bleeds

SKIN:
□ Dryness
□ Rash
□ Hair loss
□ Psoriasis
□ Sun sensitivity
□ Nodules / bumps
□ Color change to hands / feet with cold

HEME:
□ Swollen lymph nodes
□ Easy bruising

MUSCULOSKELETAL:
□ Joint pain
□ Back pain
□ Neck pain
□ Joint swelling
□ Gout flare
□ Muscle weakness
□ Stiffness in the morning
Lasting how long? ______________

CARDIAC:
□ Pain in chest
□ Irregular heartbeats
□ Palpitations

RESPIRATORY:
□ Shortness of breath
□ Cough

ABDOMINAL:
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Difficulty swallowing
□ Heartburn / reflux
□ Blood in stool
□ Nausea
□ Vomiting

URINARY:
□ Blood in urine
□ Pain / burning during urination
□ Genital rash

NEURO:
□ Dizziness
□ Persistent numbness / tingling
□ Headaches

SYMPTOMS: Check each symptom that you have had or currently have.