RHEUMATOLOGY NEW PATIENT HISTORY FORM

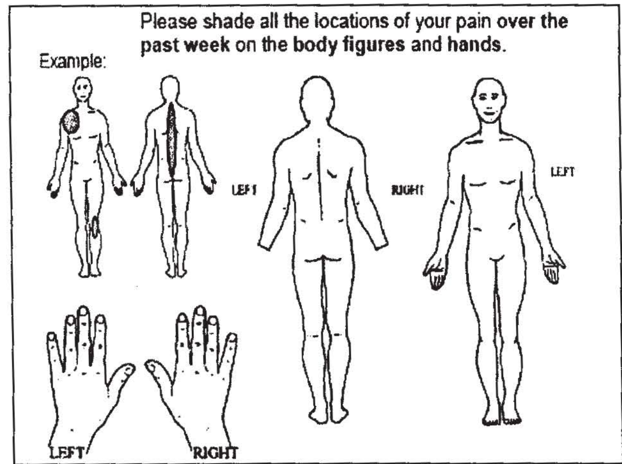
Date of first appointment: _____ /_____ /_____ Birthplace:____________ Birthdate: _____ /_____/____
Name: ____Age ______years. Gender □ F □ M
What city/town/state do you live in? ____

SOCIAL HISTORY: □ Never Married □ Married □ Divorced □ Separated □ Widowed □ Live alone □ Other
EDUCATION **(circle highest level attended)**:Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School
Occupation_____________________________ Number of hours worked/average per week_________
□ Unemployed □ Disability or □ Medical leave since _______ because of ______________________
REFERRED here by: □ Self □ Family □ Friend □ Primary Doctor □ Other _________________
Name of your primary care physician: Dr.__________________________Date of last visit ___/___/___
Do you currently see or in past saw orthopedics? □ No □ Yes, Dr______________________for_______
Do you currently see or in past saw a pain management specialist? □ No □ Yes, Dr_____________for_

REASON FOR VISIT:_________________________________.The problem started in the year____
How frequent is your problem? □ Daily □ Intermittent □ Infrequent □ Once a week □ Once a month
How did the problem begin? □ Suddenly, related to_____________ □ Gradually, related to__________
When is the problem at its worst? □ No relation to specific part of the day □ Morning □ Afternoon □ Night
Does anything make the problem worse? □ No □ Yes, it is □ Physical activity □ Walking □ Sitting □ Other_
Does anything make the problem better? □ No □ Yes, it is □ Physical activity □ Resting □ Pills □ Other___
Does the problem interfere with normal function? □ No □ Yes, it causes___________________________
Can you perform your daily activities? □ Yes *without any* difficulty □ Yes, *with some* difficulty □ Yes, *with moderate* difficulty □ Yes, *with severe* difficulty □ Not at all, I need help with____________________

YOUR CURRENT or RECENT SYMPTOMS- check all those that apply, and explain further wherever possible.
□ Pain level **(please circle one)** 0 1 2 3 4 5 6 7 8 9 10 **shade location(s) below** Duration □ days □ months □ yrs
□ Joint pain **(circle those involved)** hand – wrist – elbow –shoulder – neck - back – hip – knee– ankle - foot
□ Swelling **(circle those involved)** hand - wrist - elbow - shoulder - hip - knee - ankle - foot - toe - leg
□ Muscle pain **(circle those involved)** forearm - upper arm- neck- upper back–midback-lower back - thigh- leg
□ Morning stiffness lasts for_____minutes / hours / all day. **PLEASE SHADE LOCATION(S) OF PAIN**

□ Fatigue □ Weakness □ Fever □ Chills □ Loss of appetite □ Weight gain___lbs □ Weight loss___ lbs
□ Skin rash / nodules_____ □ Hair loss □ Bald spots
□ Tingling ___________ □ Numbness___________
□ Seizures □ Headaches □ Sudden vision loss
□ Cold sensitivity □ Heat sensitivity □ Night sweats
□ Depression □ Anxiety □ Sleep problems due to___
□ Abdominal pain □ Nausea □ Indigestion / reflux
□ Vomiting □ Diarrhea □ Constipation □ Black stools
□ Rectal bleeding □ Abnormal bleeding from_______
□ Cough / cold □ Breathing problems □ Chest pain
□ Pink / red eye □ Dry /gritty eyes □ Blurred vision
□ Ear problems □ Throat problems □ Sinus problems



□ Dry mouth □ Sores in mouth or nose □ Urinary problems □ Other_______________________
Are you physically active? □ No □Yes, if yes, please describe how__________________________
Have you had any injuries in the past? □ No □ Yes, in year _______area of body________________
Do you smoke? □ No □ Used to before □ Yes, ____ packs/cigarettes per day for _____ years.
Do you drink alcohol? □ No □ Yes □ Occasionally □ Daily, I drink ___ □ beer(s) □ wine □ other___
Do you currently use or in the past have used recreational drugs? □ No □ Yes, I use (have used)______

YOUR CURRENT OR PAST MEDICAL DIAGNOSIS **- please elaborate wherever needed.**

☐ Anemia ☐ Seasonal allergies ☐ Migraine headache ☐ Seizure / Epilepsy at age________

☐ Osteoarthritis ☐ Gout ☐ Rheumatoid arthritis ☐ Osteopenia/Osteoporosis diagnosed year

☐ Fibromyalgia ☐ Pseudogout ☐ Stroke or TIA ☐ Heart disease_________________

☐ Lupus ☐ Hepatitis B ☐ Hepatitis C ☐ Kidney disease _________________

☐ Asthma ☐ Thyroid disease ☐ Emphysema (COPD) ☐ Abnormal blood counts or transfusions

☐ Diabetes ☐ High cholesterol ☐ High blood pressure ☐ Frequent infections______________

☐ Acid reflux ☐ Ulcerative colitis ☐ Depression ☐ Anxiety / Panic attacks____________

☐ Stomach ulcer ☐ Crohn's disease ☐ Irritable bowel ☐ Cancer of _____________________

☐ Psoriasis ☐ Sleep apnea ☐ Other____

Do you see specialist(s) for conditions of eye, skin, kidney, lungs, heart, nerves, brain, hormones, bowels, stomach, blood, sinus, ear, other? Circle those that apply; give name of doctor ___________

____

ANY DRUG ALLERGIES? ☐ No ☐ Yes

Medication name Type of Reaction

1.______________________________

2.______________________________

3.______________________________

4.______________________________

PAST HOSPITALIZATION(S) & SURGERY

Reason Date Hospital

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

YOUR CURRENT MEDICATIONS

Name Dose Frequency Start date (if known)

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

6.______________________________

7.______________________________

8.______________________________

9.______________________________

10.______________________________

11.______________________________

YOUR FAMILY HISTORY- Any family member (including children) have following illness? Check if applicable

☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid arthritis ☐ Lupus ☐ Scleroderma ☐ Gout

☐ Fibromyalgia ☐ Thyroid disease ☐ High blood pressure ☐ Stroke ☐ Heart attack ☐ Cancer

☐ Depression ☐ Anxiety ☐ High cholesterol ☐ Diabetes ☐ Other________________

Does your mother have any medical problems ☐ No ☐ Yes, she has ______________________________

☐ *My mother died from* ____ *at age* ______

Does your father have medical problems? ☐ No ☐ Yes, he has_________________________________

☐ *My father died from*____*at age* ______

Please indicate how many siblings you have____ number of sister(s)______ number of brother(s) _____

MENSTRUAL & PREGNANCY HISTORY - Total number of pregnancies _____ Number of abortions ____

Number of miscarriages ____ Other complications? No ☐ Yes, ______ _____Number of children ______

Age(s)_______. Are you still having periods? ☐ Yes, ☐ regular ☐ irregular ☐ No, they stopped at age ____

Revised 8/2013