RHEUMATOLOGY: NEW PATIENT FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Social Security # _____ Birth Place: _____

HM Phone: _____ Cell / WK Phone: _____

Address: _____

City : _____ State: _____ Zip: _____

Email: _____

Referred here by: □ Self □ Family □ Friend □ Physician □ Other Health Professional

Referring Physician: _____ Primary Care Provider: _____

Do you have an orthopedic surgeon? □ Yes □ No If yes, name: _____

Reason for Today's Visit: _____

Approximately when did the symptoms began: _____ How long do they Last? _____

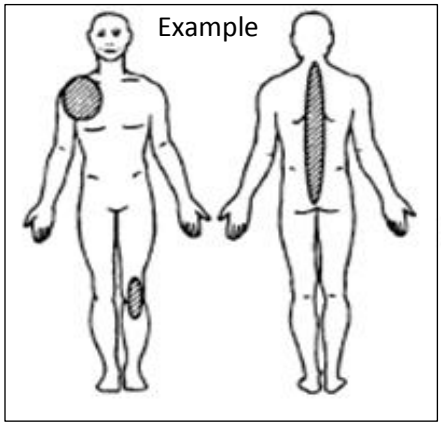
How severe are the symptoms? *(Circle One) :* **Mild** 1 2 3 4 5 6 7 8 9 10 **Severe**

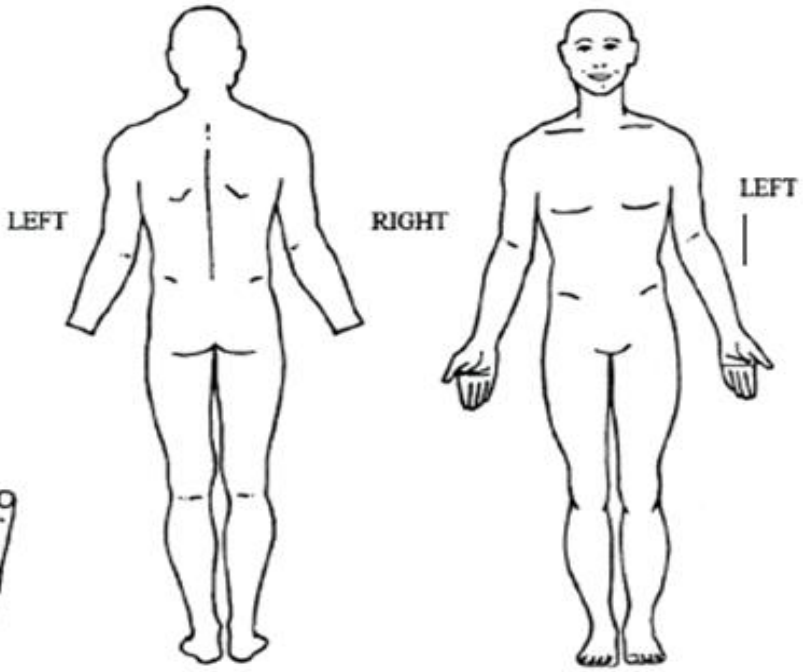
If Anything, What Aggravates the Symptoms: _____

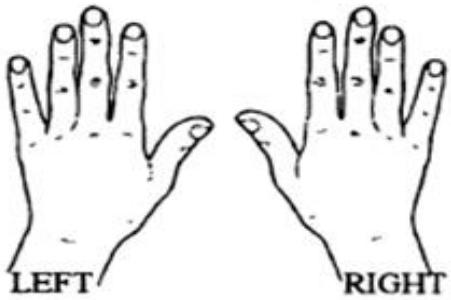
If Anything, What Relieves the Symptoms/Problem? _____

Include any previous treatment for this problem (*physical therapy, surgery, and/or injections):* _____

Please Shade all the locations of your pain over the **past week** on the **body figures** and **hands** below:







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ALLERGIES TO MEDICATIONS : Include intolerances & reactions_____

PRESENT MEDICATIONS: *List medications and include aspirin, vitamins, laxatives, herbal supplements, etc.*

Name of Medication	Dose	Length of Time	Please check: Helped?		
	strength & number of pills per day	How long have you taken this	**A lot**	**Some**	**Not at all**
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐
11.			☐	☐	☐
12.			☐	☐	☐
13.			☐	☐	☐
14.			☐	☐	☐
15.			☐	☐	☐

PAST MEDICATIONS: R*eview and indicate if you have taken any of the medications listed below, note how long, the results, and any reactions you may have had.*

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Ansaid (flurbiprofen)	☐	☐	☐	
Arthrotec (diclofenac + misoprostil)	☐	☐	☐	
Aspirin	☐	☐	☐	
Celebrex (celecoxib)	☐	☐	☐	
Clinoril (sulindac)	☐	☐	☐	
Daypro (oxaprozin)	☐	☐	☐	
Disalcid (salsalate)	☐	☐	☐	
Dolobid (diflunisal)	☐	☐	☐	
Feldene (piroxicam)	☐	☐	☐	
Indocin (Indomethacin)	☐	☐	☐	
Lodine (etodolac)	☐	☐	☐	
Meclomen	☐	☐	☐	
Motrin/Rufen (ibuprofen)	☐	☐	☐	
Trilisate (choline magnesium trisalicylate)	☐	☐	☐	
Nalfon (fenoprofen)	☐	☐	☐	
Naprosyn (naproxen)	☐	☐	☐	
Oruvail (ketoprofen)	☐	☐	☐	
Tolectin (tolmetin)	☐	☐	☐	
Voltaren (diclofenac)	☐	☐	☐	
Vioxx (rofecoxib)	☐	☐	☐	

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PAIN RELIEVERS	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Acetaminophen (Tylenol)	☐	☐	☐	
Codeine (Vicodin, Tylenol 3)	☐	☐	☐	
Propoxyphene (Darvon/Darvocet)	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDS)	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Actamra	☐	☐	☐	
Azathioprine (Imuran)	☐	☐	☐	
Benlysta	☐	☐	☐	
Cellcept	☐	☐	☐	
Cimzia	☐	☐	☐	
Cyclophosphamide (Cytoxan)	☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)	☐	☐	☐	
Etanercept (Enbrel)	☐	☐	☐	
Humira	☐	☐	☐	
Hydroxychloroquine (Plaquenil)	☐	☐	☐	
Infliximab (Remicade)	☐	☐	☐	
Methotrexate (Rheumatrex)	☐	☐	☐	
Orencia	☐	☐	☐	
Prednisone	☐	☐	☐	
Rituxan	☐	☐	☐	
Simponi	☐	☐	☐	
Sulfasalazine (Azulfidine)	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

OSTEOPOROSIS	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Alendronate (Fosamax)	☐	☐	☐	
Calcitonin injection or nasal (Miacalcin, Calcimar)	☐	☐	☐	
Denosumab (Prolia)	☐	☐	☐	
Estrogen (Premarin, etc.)	☐	☐	☐	
Etidronate (Didronel)	☐	☐	☐	
Fluoride	☐	☐	☐	
Ibandronate (*Boniva)*	☐	☐	☐	
Raloxifene (Evista)	☐	☐	☐	
Risedronate (Actonel)	☐	☐	☐	
Zoledronic acid (Reclast)	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

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GOUT	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Allopurinol (Zyloprim/Lopurin)	☐	☐	☐	
Colchicine	☐	☐	☐	
Febuxostat (Uloric)	☐	☐	☐	
Probenecid (Benemid)	☐	☐	☐	
Other:	☐	☐	☐	
OTHERS	**Please check helped:**			**Reactions**
Medication Name: *Generic (Brand)*	A lot	Some	Not at all	List any side effects
Tamoxifen (Nolvadex)	☐	☐	☐	
Tiludronate (Skelid)	☐	☐	☐	
Cortisone/Prednisone	☐	☐	☐	
Hyalgan/Synvisc injections	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	
Have you participated in any clinical trials for new medications? ☐Yes ☐ No				
If yes, list:				

SYSTEM REVIEW: Check yes or no in the box if you currently suffer from any of the following:

Constitutional			**Throat & Mouth**			**Genitourinary**		
No	**Yes**		**No**	**Yes**		**No**	**Yes**	
		Chills/Rigors			Change in taste			Change in Bladder
		Fatigue			Cold Sores			Change in urine color, if yes what color____
		Fever			Difficulty swallowing			Cloudy, "smoky" urine
		Night sweats			Hoarseness			Painful Urination
		Weight gain			Mouth sores			Difficulty with Urination
		Weight loss			Post nasal drainage			Blood in Urine
Eyes:					Sore tongue			Waking up at Night to Pass Urine
		Dry Eyes	**Respiratory:**			**Gender Specific:**		
		Double/Blurred Vision			Cough			Vaginal Dryness
		Feels like something is eye			Shortness of Breath			Genital Lesions
		Redness (eyes)			Spitting up Blood	**Integumentary:**		
		Itchy Eyes			Wheezing			Hair loss
		Eye Pain	**Gastrointestinal:**					Persistent Rash
		Vision Loss			Abdominal pain	**Neurological/Psychiatric**		
Ears:					Blood in stool			Headache
		Hearing Loss			Change in bowel habits			Numbness/Tingling (Paresthesias)
		Ringing in ears			Constipation	**Cardiovascular**		
Nose & Sinus:					Diarrhea			Chest pain
		Loss of Smell			Heartburn			Irregular heart beat/palpitations
		Nosebleeds			Jaundice			Shortness of Breath at Night
		Nose Sores			Nausea/ Vomiting			Swelling in Legs or Feet
Musculoskeletal								
		Muscle Pain			Muscle Weakness			
		Morning stiffness, if yes lasting how long _____minutes/hours.						
		Bone/Joint Symptoms: list joints affected in the last six months_____						

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MEDICAL HISTORY: *Check if you have been diagnosed with any of the following conditions:*

☐ Allergies	☐ Depression	☐ Headache/ Migraines	☐ Osteoporosis
☐ Anemia	☐ Diabetes type 1 or 2	☐ Heart Disease	☐ Pneumonia
☐ Angina	☐ Elevated Lipids	☐ Hyperlipidemia	☐ Psoriasis
☐ Anxiety	☐ Emphysema	☐ Hypertension	☐ Psychiatric Disorders
☐ Arthritis	☐ Epilepsy	☐ Irritable Bowel	☐ Rheumatic Fever
☐ Asthma	☐ Gallbladder Disease	☐ Leukemia	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ GERD	☐ Liver Disease	☐ Seizure Disorder
☐ Blood Clots	☐ Goiter	☐ Lupus or 'SLE'	☐ Stroke
☐ COPD	☐ Gout	☐ Myocardial Infarction	☐ Stomach Ulcers
☐ Crohn's Disease	☐ HIV/AIDS	☐ Osteoarthritis	☐ Thyroid Disorder
☐ Colitis			☐ Tuberculosis (TB)

☐ Hepatitis/Liver Disease:	☐ A, ☐ B, ☐ C, ☐ D, ☐ E, ☐ F, ☐ GBV-C, ☐ autoimmune, ☐ drug induced	☐:
☐ Cancer (list type):	☐ bladder, ☐ breast, ☐ colon, ☐ gastric, ☐ lung, ☐ thyroid, ☐ neck, ☐ ovarian	☐:
☐ Renal (Kidney) Disease:	☐ on dialysis, ☐ Stage 1-2, ☐ stage 3-4, ☐ stage 5 (end)	☐:

☐ Other Conditions not Listed: _____

SURGICAL HISTORY: *Check if you have had any of the following surgeries:*

☐ Angioplasty	Date:	_____	☐ Colectomy	Date:	_____
☐ Appendectomy	Date:	_____	☐ Gastric Bypass	Date:	_____
☐ Arthroscopy	Date:	_____	☐ Hernia Repair	Date:	_____
☐ Back Surgery	Date:	_____	☐ Hip Replacement	Date:	_____
☐ Blood Transfusion	Date:	_____	☐ Knee Replacement	Date:	_____
☐ CABG	Date:	_____	☐ LASIK	Date:	_____
☐ Cardiac Pacemaker	Date:	_____	☐ Fracture Repair	Date:	_____
☐ Carpal Tunnel Release	Date:	_____	☐ Thyroidectomy	Date:	_____
☐ Cataract Extraction	Date:	_____	☐ Tonsillectomy	Date:	_____
☐ Cholecystectomy	Date:	_____	☐ Mastectomy	Date:	_____

☐ Other Surgeries: _____

Hospitalized for any Reason? ☐ No ☐ Yes, explain the reason

_____Duration :_____

DIAGNOSTIC TESTING:

Last Mammogram	Date:	_____	**Last Tuberculosis Test**	Date:	_____
Last chest X-Ray	Date:	_____	**Other**	Date:	_____
Last Bone Densitometry	Date:	_____	**Other**	Date:	_____
Last Eye Exam	Date:	_____	**Other**	Date:	_____

GYNECOLOGICAL HISTORY *(woman only)***:**

Age of Menarche: _____ Last Pap: _____ Age of Menopause: _____

Periods Regular: ☐ No ☐ Yes How many days apart: _____ Bleeding after Menopause: _____

Last Menstrual Period: _____ HRT: ☐ No ☐ Yes Hysterectomy ☐ No ☐ Yes, type: _____

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Number of Pregnancies: _____ Number of Miscarriages : _____

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FAMILY HISTORY: Circle the letter that represents the family member: Mother (M), Father (F), Sister (S), Brother (B)

Father: ☐ Alive & Well , ☐ Deceased Age _____ **Mother**: ☐ Alive & Well, ☐ Deceased Age _____

Alcoholism	M	F	S	B	Heart Disease	M	F	S	B
Allergies	M	F	S	B	Hyperlipidemia	M	F	S	B
Ankylosing Spondylitis	M	F	S	B	Hypertension	M	F	S	B
Asthma	M	F	S	B	Leukemia	M	F	S	B
Arthritis	M	F	S	B	Lupus "SLE"	M	F	S	B
Autoimmune Disease	M	F	S	B	Migraines	M	F	S	B
Bleeding Tendency	M	F	S	B	Obesity	M	F	S	B
CAD	M	F	S	B	Osteoarthritis	M	F	S	B
Cancer	M	F	S	B	Osteoporosis	M	F	S	B
Childhood Arthritis	M	F	S	B	Psoriasis	M	F	S	B
Colitis	M	F	S	B	Renal Disease	M	F	S	B
CVA (Stroke)	M	F	S	B	Rheumatoid Arthritis	M	F	S	B
Depression	M	F	S	B	Rheumatic Fever	M	F	S	B
Diabetes	M	F	S	B	Thyroid Disorder	M	F	S	B
Epilepsy	M	F	S	B	Tuberculosis	M	F	S	B
Gout	M	F	S	B	Other:_____	M	F	S	B

SOCIAL HISTORY:

Tobacco Use: *Do you use TOBACCO? ☐ No/Never, ☐ Yes, ☐ Former - How long ago? _____

Type ☐ cigarette, ☐ cigarillo, ☐ cigar, ☐ pipe, ☐ chew, ☐ smokeless, ☐ snuff

Smoker Status ☐ current every day smoker, ☐ current some day smoker, ☐ heavy smoker, ☐ light smoker

How long have you used tobacco? _____ Packs per day: _____

Alcohol: Do you drink ALCOHOL: ☐ No ☐ Yes, how often _____ how much _____

Has anyone ever told you to cut down on drinking? ☐No ☐ Yes

Caffeine: Do you drink/consume CAFFEINE? ☐ No ☐ Yes, type of caffeine _____

Confidential: Do you use drugs for reasons that are not medical? ☐No ☐ Yes, please list: _____

Lifestyle: Do you EXERCISE? ☐ No ☐ Yes, how often _____ how long _____

Level of Activity: ☐ Sedentary ☐ Moderate ☐ Vigorous

Sleep Patterns: How many hours of sleep do you get at night?_____ Trouble falling asleep? ☐No ☐ Yes

Difficultly staying asleep? ☐No ☐Yes Do you wake up feeling rested? ☐No ☐Yes

Marital Status: ☐ Never Married ☐ Married ☐Divorced ☐Separated ☐Widowed

Spouse/Significant Other: ☐ Alive/Age____ ☐ Deceased/Age____ ☐ Major Illness_____

Education: *(circle highest level):* Grade School: 7 8 9 10 11 12 College: 1 2 3 4 Graduate School

Occupation: Type of work_____ Number of hours worked/average per week _____

Immunizations: Date of Last Flu Shot _____ Date of Last Pneumonia Shot: _____

Sign: _____

(Patient or responsible party)