New Patient History Form

Medical Center Clinic℠
RHEUMATOLOGY DEPARTMENT

Date: _____ Birth Date: _____

Name: _____ Age: _____ Sex at birth: ☐F ☐M

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ ☐ Home ☐ Work ☐ Cell

_____ ☐ Home ☐ Work ☐ Cell

Referred by:

☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional

Name of person making referral: _____

Primary Care Physician: _____

Do you have an orthopaedic surgeon? ☐Yes ☐No If yes, name: _____

Date symptoms began (approximate): _____

Briefly describe your present symptoms:

_____

_____

_____

_____

Diagnosis given? ☐No ☐Yes (please list)

_____

_____

Previous treatment for this problem: (include physical therapy, surgery, and injections. Medications will be listed later.)

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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Rheumatologic (Arthritis) History:

At any time, have you or a blood relative had any of the following: *(please check if yes)*

	Yourself	Blood Relative	Relationship
Arthritis	☐	☐	_____
Osteoarthritis	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Gout	☐	☐	_____
Lupus or "SLE"	☐	☐	_____
Anklyosing Spondylitis	☐	☐	_____
Childhood arthritis	☐	☐	_____
Osteoporosis	☐	☐	_____
Other Arthritis Conditions:	☐	☐	_____

_____

_____

_____

Review of Systems: *Please check all that apply:*

General:

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

Nervous System:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasms
- ☐ Loss of consciousness

Ears:

- ☐ Ringing in ears
- ☐ Loss of hearing

Eyes:

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feeling of something in your eye

Nose:

- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness

Mouth:

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness

Throat:

- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Difficulty in swallowing

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Review of Systems - continued: *Please check all that apply:*

Neck:

- ☐ Swollen Glands
- ☐ Tender Glands

Heart and Lungs:

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heartbeat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ High blood pressure
- ☐ Heart murmurs
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Night sweats

Stomach and Intestines:

- ☐ Nausea
- ☐ Vomiting of blood or coffee-ground material
- ☐ Yellow jaundice
- ☐ Stomach pain relieved by food or milk
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stool
- ☐ Heartburn

Kidney, Urine, and Bladder:

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis / vagina
- ☐ Frequent urinations
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash / ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

Blood:

- ☐ Anemia
- ☐ Bleeding Tendency

Menstrual:

Age when periods began: _____

Are your periods regular? _____

How Many Days Apart? _____

Date of Last Period: _____

Date of Last Pap Smear: _____

Bleeding after menopause: _____

Skin:

- ☐ Easy Bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules / bumps
- ☐ Hair loss
- ☐ Color changes of hands/feet in cold

Muscles, joints, and bones:

- ☐ Morning stiffness lasting how long?

  Minutes Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling, list joints affected in the last 6 months:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Habits:

Do you drink coffee? ☐ Yes ☐ No How many cups per day? _____

Do you smoke? ☐ Yes ☐ No Cigarettes per day? _____

Alcohol Intake: ☐ Heavy ☐ Moderate ☐ Light ☐ None

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

If yes, please list: _____

Date of last eye examination: _____

Date of last chest x-ray: _____

Date of last tuberculosis test: _____

Past Personal History:

Do you or have you had: *(please mark if yes)*

- ☐ Cancer
- ☐ Leukemia
- ☐ Epilepsy
- ☐ Bad headaches
- ☐ Pneumonia

If you selected cancer, please specify type, or list any other significant illness: (please list)

_____

_____

Previous Operations:

Type	Year	Surgeon	City
1.			
2.			
3.			
4.			
5.			
6.			

Previous fractures? ☐ Yes ☐ No Please describe: _____

Other serious injuries? ☐ Yes ☐ No Please describe: _____

_____

_____

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Family History:

Do you know of any blood relative who has or has had: (check and give relationship)

- ☐ Asthma _____
- ☐ Alcoholism _____
- ☐ Bleeding tendency _____
- ☐ Cancer (Specific Type) _____
- ☐ Colitis _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Goiter _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Leukemia _____
- ☐ Rheumatic Fever _____
- ☐ Stroke _____
- ☐ Tuberculosis _____

Marital Status:

☐ Never married ☐ Married ☐ Divorced ☐ Separated

Spouse: If living, age _____ If deceased, age at death _____

Major illnesses: _____

Education: *(Highest Grade/Level/Degree Attained)*

_____

Occupation: _____ Number of hours worked per week _____

Please check the one best answer for your abilities at this time:

Over the last week, were you able to:	**Without ANY Difficulty**	**With SOME Difficulty**	**With MUCH Difficulty**	**UNABLE To Do**
Dress yourself, including tying shoelaces and doing buttons?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wash and dry your entire body?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of a car, bus, train, or airplane?	☐	☐	☐	☐
Walk two miles or three kilometers?	☐	☐	☐	☐
Participate in recreational activities and sports?	☐	☐	☐	☐

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How much pain have you had because of your condition over the past week ?

No Pain **Pain as bad as it could be**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

Very Well **Very Poorly**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

Medications:

Any drug allergies? _____ Yes _____ No

If Yes, which drugs and reactions?

_____

_____

_____

Current Medication List:

(List ALL medications that you are taking at this time. Include items such as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose (Include strength and number of pills per day)	How long have you taken this medication?	Please check one, did the medication help? Yes	Some	No
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

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