New Rheumatology Patient

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Patient Name: _____ Date: _____

Referred by: (circle one) Self Family Friend Doctor Other Healthcare Professional

Name of Referring Party: _____

Date Symptoms Began: _____

Diagnosis Given: _____

Chief Complaint (present symptoms):
_____
_____
_____

Joints Affected in the last 6 months: (circle all that apply)

Fingers	Hands	Wrists	Elbows	Shoulders
Neck	Upper	Upper Back	Middle Back	Lower Back
Hips	Knees	Ankles	Feet	Toes

Previous Treatment Received: _____

Previous Fracture: Yes_____ No_____

Previous Serious Injury: Yes_____ No_____

Most of the time, you function: (circle one) Very Poorly Poorly Okay Well Very Well

Difficulties:

	Usually	Sometimes	Never
Using Hands to Grasp Small Objects			
Walking			
Climbing Stairs			
Descending Stairs			
Sitting Down			
Getting Up From a Chair			
Touching Feet While Seated			
Reaching Behind Back			

Patient Name: _____ Date: _____

Difficulties:

	Usually	Sometimes	Never
Getting Dressed			
Going to Sleep			
Staying Asleep Due to Pain			
Obtaining Restful Sleep			
Bathing			
Eating			
Working			
Getting Along with Family			
Sexual Relationships			
Leisure Time Activities			

Morning Stiffness: (circle one) Usually Sometimes No

How Long Morning Stiffness Lasts: (circle one) 15-30 minutes 30 minutes-1 hour 2 hours or more

Do you get enough sleep at night? Yes_____ No_____
Do you wake up feeling rested? Yes_____ No_____
Are you receiving disability? Yes_____ No_____
Are you applying for disability? Yes_____ No_____

Family Rheumatologic History: (circle all that apply)

Arthritis	Osteoarthritis	Rheumatoid Arthritis	Gout
Lupus or SLE	Ankylosing Spondylitis	Childhood Arthritis	Osteoporosis
Cancer	Heart Disease	Rheumatic Fever	Tuberculosis
Leukemia	High Blood Pressure	Epilepsy	Diabetes
Stroke	Bleeding Tendencies	Asthma	Goiter
Colitis	Alcoholism	None	

Other (describe):_____

Personal Rheumatologic History: (circle all that apply)

Arhtritis	Osteoarthritis	Rheumatoid Arthritis
Gout	Lupus or SLE	Ankylosing Spondylitis
Childhood Arthritis	Osteoporosis	None

Patient Name: _____ Date: _____

Arthritis Drugs Tried in the Past: (circle all that apply)

Aspirin	Products containing Aspirin	Easpirin
Disalcid	Tylenol	Tylenol with Codeine
Darvon/Darvocet	Clinoril	Feldene
Indocin	Arava	Motrin/Rufen
Enbrel	Naprosyn	Remicaide
Cortisone	Colcheceine	Gold (shots or pills)
Imuran	Cytoxan	Methotrexate
Plaquenil	Penicillamine	

Other (describe): _____

Side Effects: (circle all that apply)

Shortness of Breath	Nausea	Vomiting	Fainting
Itching	Urticaria (Hives)	Dizziness	Drowsiness
Diaphoresis			

Other (describe): _____

Past Personal History: (circle all that apply)

Cancer	Heart Disease	Rheumatic Fever	Tuberculosis
Leukemia	High Blood Pressure	Epilepsy	Diabetes
Stroke	Bleeding Tendencies	Asthma	Goiter
Colitis	Alcoholism		

Any Other Significant Illnesses:
_____

Previous Surgeries (description and approximate date):
_____
_____
_____
_____

Social History:
Occupation: _____

Hours Worked per week: (circle one) 0-5 5-10 10-20 20-40 40 or more

Do you drink coffee? Yes_____ No_____ Cups per Day: _____

Do you smoke? Yes_____ No_____ Cigarettes per Day: _____

Patient Name: _____ Date: _____

Do you drink alcoholic beverages? Yes_____ No_____ Number of Drinks per Week:_____
Have you ever been told to cut down on drinking alcohol? Yes_____ No_____

Have you ever used drugs for non-medical reasons? Yes_____ No_____

Home Conditions: House_____ Apartment_____ Other_____

Do you have stairs to climb? Yes_____ No_____ If yes, how many? _____

Number of people in household: _____

Who does most of the housework? _____

Who does most of the shopping? _____

Physical Exam: (circle all that apply)

Systems Review:

General: Recent Weight Gain ___ Recent Weight Loss ___ Fatigue ___ Fever ___ Weakness ___ None ___

Neck: Swollen Glands ___ Tender Glands ___ None ___

Skin: Easy Bruising ___ Redness ___ Rash ___ Hives ___ Sun Sensitive ___ Tightness ___ Nodules/Bumps ___ Hair Loss ___ Color changes of hands/feet in cold ___ None ___

Nervous System: Headaches ___ Dizziness ___ Fainting ___ Muscle Spasm ____ Loss of Consciousness ___ Sensitivity or Pain in Hands/Feet ___ Memory Loss ___ None ___

Ears: Ringing in Ears ___ Loss of Hearing ___ None ___

Eyes: Pain ___ Redness ___ Loss of Vision ___ Doubled or blurred vision ___ Dryness ___ Foreign body sensation ___ None ___

Nose: Nosebleeds ___ Loss of Smell ___ Dryness ___ None ___

Mouth: Sore Tongue ___ Bleeding gums ___ Sore in Throat ___ Loss of Taste ___ Dryness ___ None ___

Throat: Frequent Sore Throats ___ Hoarseness ___ Difficulty Swallowing ___ None ___

Heart and Lungs: Chest Pain ___ Irregular Heart Beat ___ Sudden Changes in Heartbeat ___ Shortness of Breath ___ Difficulty Breathing at Night ___

Patient Name: _____ Date: _____

Swollen Legs or Feet ___ High Blood Pressure ___ Heart Murmurs ___
Cough ___ Coughing up blood ___ Wheezing ___ Night Sweats ___
Vomiting of Blood or material that represents coffee grounds ___
Stomach Pain relieved by food or milk ___ Yellow Jaundice ___ Heartburn ___
Increasing Constipation ___ Persistent Diarrhea ___ Blood in Stools ___
Black Stools ___ None ___

Kidney/Bladder/Urine: Difficulty in Urination ___ Pain or Burning during Urination ___
Blood in Urine ___ Cloudy ___ Sticky Urine ___ Pus in Urine ___
Discharge from Penis/Vagina ___ Frequent Urination ___
Getting up at night to pass urine ___ Vaginal Dryness ___ Rash ___
Ulcers ___ Sexual Difficulties ___ Prostate Trouble ___ None ___

Blood: Bleeding Tendencies ___ Anemia ___ None ___

Muscles/Joints/Bones: Morning Stiffness ___ Joint Pain ___ Muscle Weakness ___
Muscle Tenderness ___ Joint Swelling ___ None ___

Allergies:

_____
_____
_____
_____

Current Medications & Dosages:

_____
_____
_____
_____
_____
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