# New Rheumatology Patient

Patient Name _____ Date _____

Referred by (check box) Self Family Friend Doctor Other Healthcare professional

Name of referring party _____

Date symptoms began _____

Diagnosis given _____

Chief complaints (present symptoms) _____

_____

_____

**Joints affected in the last 6 months (check all that apply)**
Fingers☐ Hands☐ Wrists☐ Elbows☐ Shoulders☐ Neck☐ Upper back☐
Middle back☐ Lower back☐ Knees☐ Ankles☐ Feet ☐ Toes☐
Previous treatment received _____
Answer Yes or No
Previous fracture? _____ Previous serious injury? _____

**Most of the time you function (check 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 | ○ | ○ | ○ |
| Sexual relationships | ○ | ○ | ○ |
| Leisure time activities | ○ | ○ | ○ |

**Morning stiffness**
How long does morning stiffness last (check one) 15-30 minutes☐ 30-60 minutes☐ 2 hours or more☐
Answer Yes or No
Do you get enough sleep at night _____ Do you wake up feeling rested _____
Are you receiving disability _____ Are you applying for disability _____

**Family Rheumatologic History (check 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 _____

**Personal Rheumatologic History (check all that apply)**
Arthritis☐Osteoarthritis☐Rheumatoid arthritis☐ Gout☐ Lupus or SLE☐
Ankylosing Spondylitis☐ Childhood arthritis☐ Osteoporosis☐ None☐

**Arthritis drugs tried in the past (check all that apply)**
Aspirin☐ Products containing aspirin ☐ Disalcid☐ Tylenol ☐ Tylenol w/ codeine ☐
Darbon/ Darvocet☐Clinoril☐ Feldene☐ Indocin☐ Arava☐ Motrin/ rufen☐ Enbrel☐
Naprosyn☐ Remicade☐ Cortisone☐ Colcheceine☐Gold (pills or shots)☐ Imuran☐
Cytoxan☐ Methotrexate☐ Plaquenil☐ Penicillamine☐
Other _____

**Side Effects (check all that apply)**
Shortness of breath☐ Nausea☐ Vomiting☐ Fainting☐ Itching☐ Urticaria (Hives)☐
Dizziness☐ Drowsiness☐ Diaphoresis☐
Other _____

**Past Personal History, (check 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: _____

_____

_____

_____

_____

**Social History**

Occupation _____

Hours worked per week (check one) 0-5 ☐ 5-10 ☐ 10-20☐ 20-40☐ 40 or more☐
Answer Yes or No
Do you drink coffee? _____ Cups per day _____
Do you smoke? _____ Cigarettes per day _____
Do you drink alcoholic beverages? _____ Drinks per week _____

Have you ever been told to cut down on drinking alcohol? _____
Have you used drugs for non-medical reasons? _____

**Home Conditions**

Do you live in (check one) House☐ Apartment☐ Condominium☐

Other _____
Do you have stairs? _____ if yes, how many _____
Number of people in household _____
Who does most of the housework? _____
Who does most of the shopping? _____

**Physical Exam (check all that apply)**

**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 when 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 throat☐ Hoarseness☐ Difficulty swallowing☐ None☐

**Heart and Lungs:** Chest pain☐ Irregular heart beat☐ Sudden changes in heart beat☐
Shortness of breath☐ Difficulty breathing at night☐
Swollen legs or feet☐ High blood pressure☐ Heart murmurs☐
Cough☐ Coughing up blood☐ Wheezing☐ Night sweats☐
Vomiting of blood or material that looks like 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 urinating ☐ 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 urinate ☐ 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 and dosages: _____

_____

_____

_____

_____

_____