



Patient Name: _____ MR #: _____

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? _____

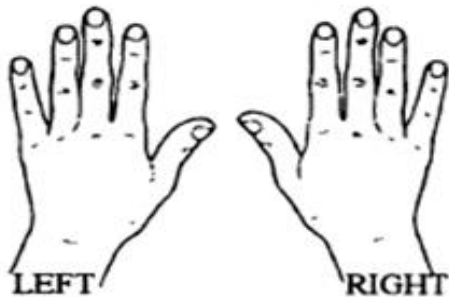
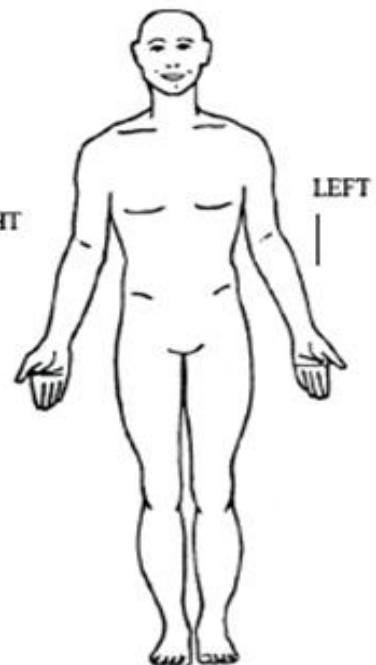
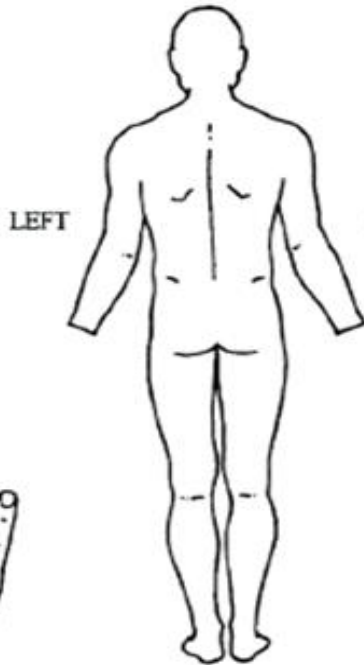
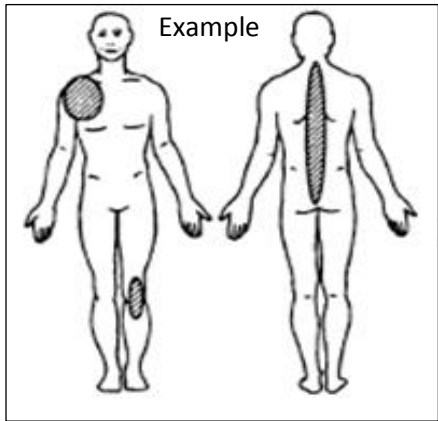
How severe are the symptoms? (Circle One): **Mild** 1 2 3 4 5 6 7 8 9 10 **Severe**

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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS: Review 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) Medication Name: <i>Generic (Brand)</i>	Please check helped:			Reactions
	A lot	Some	Not at all	List any side effects
Ansaid (flurbiprofen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrotec (diclofenac + misoprostil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Celebrex (celecoxib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinoril (sulindac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daypro (oxaprozin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disalcid (salsalate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dolobid (diflunisal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feldene (piroxicam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indocin (Indomethacin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lodine (etodolac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meclomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin/Rufen (ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trilisate (choline magnesium trisalicylate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nalfon (fenoprofen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naprosyn (naproxen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oruvail (ketoprofen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tolectin (tolmetin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voltaren (diclofenac)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vioxx (rofecoxib)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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PAIN RELIEVERS	Please check helped:			Reactions
Medication Name: <i>Generic (Brand)</i>	A lot	Some	Not at all	List any side effects
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDS)				
Medication Name: <i>Generic (Brand)</i>	A lot	Some	Not at all	Reactions
Actamra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List any side effects
Azathioprine (Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Benlysta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cellcept	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cimzia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Humira	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orencia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituxan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Simponi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OSTEOPOROSIS				
Medication Name: <i>Generic (Brand)</i>	A lot	Some	Not at all	Reactions
Alendronate (Fosamax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List any side effects
Calcitonin injection or nasal (Miacalcin, Calcimar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Denosumab (Prolia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Estrogen (Premarin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ibandronate (<i>Boniva</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zoledronic acid (Reclast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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GOUT	Please check helped:			Reactions
Medication Name: <i>Generic (Brand)</i>	A lot	Some	Not at all	List any side effects
Allopurinol (Zyloprim/Lopurin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Febuxostat (Uloric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Probenecid (Benemid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHERS				
Medication Name: <i>Generic (Brand)</i>	A lot	Some	Not at all	List any side effects
Tamoxifen (Nolvadex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you participated in any clinical trials for new medications? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	Chills/Rigors	<input type="checkbox"/>	Change in taste	<input type="checkbox"/>	Change in Bladder
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	Change in urine color, if yes what color _____
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Cloudy, "smoky" urine
<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	Mouth sores	<input type="checkbox"/>	Difficulty with Urination
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Post nasal drainage	<input type="checkbox"/>	Blood in Urine
Eyes:		<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	Waking up at Night to Pass Urine
<input type="checkbox"/>	Dry Eyes	Respiratory:		Gender Specific:	
<input type="checkbox"/>	Double/Blurred Vision	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Vaginal Dryness
<input type="checkbox"/>	Feels like something is eye	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Genital Lesions
<input type="checkbox"/>	Redness (eyes)	<input type="checkbox"/>	Spitting up Blood	Integumentary:	
<input type="checkbox"/>	Itchy Eyes	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	Eye Pain	Gastrointestinal:		<input type="checkbox"/>	Persistent Rash
<input type="checkbox"/>	Vision Loss	<input type="checkbox"/>	Abdominal pain	Neurological/Psychiatric	
Ears:		<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	Headache
<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	Numbness/Tingling (Paresthesias)
<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	Constipation	Cardiovascular	
Nose & Sinus:		<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Irregular heart beat/palpitations
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Shortness of Breath at Night
<input type="checkbox"/>	Nose Sores	<input type="checkbox"/>	Nausea/ Vomiting	<input type="checkbox"/>	Swelling in Legs or Feet
Musculoskeletal					
<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	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:

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

- | | | | |
|--|-------------|---|-------------|
| <input type="checkbox"/> Angioplasty | Date: _____ | <input type="checkbox"/> Colectomy | Date: _____ |
| <input type="checkbox"/> Appendectomy | Date: _____ | <input type="checkbox"/> Gastric Bypass | Date: _____ |
| <input type="checkbox"/> Arthroscopy | Date: _____ | <input type="checkbox"/> Hernia Repair | Date: _____ |
| <input type="checkbox"/> Back Surgery | Date: _____ | <input type="checkbox"/> Hip Replacement | Date: _____ |
| <input type="checkbox"/> Blood Transfusion | Date: _____ | <input type="checkbox"/> Knee Replacement | Date: _____ |
| <input type="checkbox"/> CABG | Date: _____ | <input type="checkbox"/> LASIK | Date: _____ |
| <input type="checkbox"/> Cardiac Pacemaker | Date: _____ | <input type="checkbox"/> Fracture Repair | Date: _____ |
| <input type="checkbox"/> Carpal Tunnel Release | Date: _____ | <input type="checkbox"/> Thyroidectomy | Date: _____ |
| <input type="checkbox"/> Cataract Extraction | Date: _____ | <input type="checkbox"/> Tonsillectomy | Date: _____ |
| <input type="checkbox"/> Cholecystectomy | Date: _____ | <input type="checkbox"/> Mastectomy | Date: _____ |
| <input type="checkbox"/> 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)