RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: ___________________________ DOB: ___________ Date: ___________

This questionnaire is to get information that would help in the assessment of your health problem(s). Please try to answer each question, even if you do not think it is related to you at this time. Thank you.

PAST MEDICAL HEALTH:
Have you ever been told by a doctor/healthcare provider that you have any of the following?
(If “yes” check the appropriate box)

- Diabetes
- High blood pressure
- High Cholesterol
- Heart Attack
- Angina
- Congestive Heart Failure
- Other heart disease (please describe) ___________________________________________________________________
- Asthma
- COPD/Emphysema
- Acid reflux or GERD
- Peptic ulcer disease
- Hepatitis
- Crohn’s Disease/Ulcerative Colitis
- Blood clots in legs or lungs
- Peripheral vascular disease
- Thyroid disease
- Kidney disease
- Depression
- Anxiety or Panic disorder
- Stroke or Mini Stroke
- Epilepsy (Seizures)
- Neurological disease such as Multiple Sclerosis or Parkinson’s disease
- Chronic back pain (degenerative disc disease spinal stenosis)
- Visual impairment such as cataract, glaucoma, or macular degeneration
- Hearing impairment such as very hard of hearing even with hearing aids
- Cancer (please describe) ____________________________________________________________
- Other significant illnesses (please list) ___________________________________________________________________

SURGERIES/OPERATIONS: ____________________________________________________________

Please record your current:

- Weight ____________________________
- Height ____________________________

SOCIAL/PERSONAL HISTORY:

What is your highest education level?

- Grade School
- High School
- Some college courses
- College graduate
- Advanced degree

At this time are you?

- Working full time
- Working part time
- Unemployed
- Retired
- Student
- Homemaker-full time

Current or past occupation(s) ____________________________________________________________

Are you currently on disability or SSI?

- Yes
- No

Marital Status

- Never married
- Married
- Divorced
- Separated
- Widowed

Have you ever smoked on a regular basis?

- Yes
- No

How many packs did (do) you smoke per day? _____________ At what age did you start smoking? _____________

Do you smoke at this time?

- Yes
- No

If “No”, at what age did you stop smoking? _____________

Do you drink alcohol?

- Yes
- No

If “Yes”, type of drink __________________________ Number per week _______________

Have you used drugs for any reasons that are not medical?

- Yes
- No

If “Yes” please list ________________________________________________________________
REVIEW OF SYSTEMS
Please check any problems that may have significantly affected you:

General:
☐ Fatigue  ☐ Fever  ☐ Loss of Appetite  ☐ Night Sweats
☐ Recent weight loss; how much________________  ☐ Recent weight gain; how much________________

Eyes:
☐ Redness  ☐ Eye Pain  ☐ Decreased vision
☐ Dry Eyes  ☐ Scratchy Eyes  ☐ Use tear drops more than 3 times a day
☐ Any history of eye inflammation (i.e. uveitis, iritis etc.)

ENT:
☐ Problems with hearing  ☐ Need to frequently drink liquids to help in swallowing dry food
☐ Daily feeling of dry mouth for more than 3 months  ☐ Ear pain  ☐ Sores in mouth or nose

Cardiovascular:
☐ Chest pain  ☐ Palpitations  ☐ Leg swelling (edema)

Respiratory:
☐ Chest pain with deep breathing (i.e. pleurisy)  ☐ Cough
☐ Shortness of breath  ☐ Wheezing  ☐ Coughing of blood
☐ Difficulty breathing on lying flat  ☐ Shortness of breath with activity

Gastrointestinal:
☐ Heartburn  ☐ Nausea  ☐ Vomiting  ☐ Swallowing difficulties
☐ Stomach or abdomen pain  ☐ Constipation  ☐ Diarrhea  ☐ Blood in stools

Genito-urinary:
☐ Increase in urinary frequency  ☐ Burning or pain on urination  ☐ Blood in Urine
For women only: Do you have menstrual period? ☐ Yes  ☐ No  # of pregnancies_____ Miscarriages_____

Musculoskeletal:
☐ Joint pain  ☐ Joint swelling  ☐ Muscle pain or aches  ☐ Muscle weakness

Skin:
☐ Rash on cheeks (butterfly shaped)  ☐ Other rashes  ☐ Rash or feeling sick after going in the sun
☐ Skin color changes in fingers/toes with cold exposure

Neurologic:
☐ Headaches  ☐ Numbness or tingling in arms/legs  ☐ Weakness in arms/legs
☐ Memory loss  ☐ Difficulty in thinking or concentration

Endocrine:
☐ Hot Flashes  ☐ Night Sweats  ☐ Thyroid Problems  ☐ Bald patches or severe hair loss

Hematologic/Lymph:
☐ Swollen glands  ☐ Blood Clots  ☐ History of Miscarriage  ☐ History of low platelets/blood count
Name: ___________________________ DOB: __________ Date: __________

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle to indicate your fatigue:

Fatigue is major
No problem  0  0.5  1  1.5  2  2.5  3  3.5  4  4.5  5  5.5  6  6.5  7  7.5  8  8.5  9  9.5  10 problem

When you awakened in the morning OVER THE PAST WEEK, did you feel stiff? ☐ Yes ☐ No

If “yes” please write the number of minutes ______ or hours ______ until you are as limber as you will be for the day. Also describe the overall level of stiffness that you have had when you wake up. Please circle to indicate your stiffness.

None  0  0.5  1  1.5  2  2.5  3  3.5  4  4.5  5  5.5  6  6.5  7  7.5  8  8.5  9  9.5  10 Very Severe

Please inform us of any major health problems in your family members:

Father __________________________________________________________

Mother __________________________________________________________

Sibling(s) _______________________________________________________

Others __________________________________________________________

Medications

What medicines are you taking? Please list BOTH prescription and non-prescription.

1. __________________________________________ Dose ___________ Times per day _______ How long _______

2. __________________________________________ Dose ___________ Times per day _______ How long _______

3. __________________________________________ Dose ___________ Times per day _______ How long _______

4. __________________________________________ Dose ___________ Times per day _______ How long _______

5. __________________________________________ Dose ___________ Times per day _______ How long _______

6. __________________________________________ Dose ___________ Times per day _______ How long _______

Are you allergic to any medications? ____________________________

Physician’s Signature ___________________________ Date ___________