RHEUMATOLOGY NEW PATIENT QUESTIONAIRE

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_____

Name:_____DOB:_____Date:_____

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 (edma)

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