RHEUMATOLOGY CLINIC

New Patient Questionnaire

(Please complete both sides of this form)

Name: ______________________________ **Date:** ____________________

Personal History

Birthplace: ____________________ Date of Birth: ____________________

Nationality: ____________________ Religious Affiliation: ____________________

Marital / Relationship Status: ______________________________

Employment Status / Occupation: ______________________________

Exercise: ____________________ Hobbies: ____________________

Average Per Day: Alcohol (type): ____________________ Recreational Drug Use: ____________________

Tobacco: ____________________ Tea / Coffee: ____________________

Medications Taken Regularly

(include prescription and over-the-counter)

____________________ ____________________

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Medication Allergies: ____________________

____________________ ____________________

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Immunizations

Pneumovax (pneumonia)....... ❑ Yes ❑ No Year: ________

Hepatitis A........................... ❑ Yes ❑ No Year: ________

Hepatitis B .... ❑ Yes ❑ No Year: ________

Tetanus............................... ❑ Yes ❑ No Year: ________

Polio.................................... ❑ Yes ❑ No Year: ________

Small Pox .... ❑ Yes ❑ No Year: ________

Other: ______________________________ Year: ________

X-rays / Procedures

Chest x-ray .... Year of Last Test: __________

Mammogram .... Year of Last Test: __________

Colonoscopy............................ Year of Last Test: __________

Bone Density Scan .... Year of Last Test: __________

Prostate Exam (Men)............... Year of Last Test: __________

TB Skin Test (PPD).................. Year of Last Test: __________

Other: __________________ Year of Last Test: __________

Other: __________________ Year of Last Test: __________

Family History

	Present age, or age at death	If living, health (good, fair, poor); If deceased, cause of death
Father		
Mother		
Brothers / Sisters		
1.		
2.		
3.		
4.		
5.		

Is there any family history (in parents, siblings or children) of any of the following:

Arthritis	❑ No	❑ Yes	Who: ________
Lupus	❑ No	❑ Yes	Who: ________
Scleroderma	❑ No	❑ Yes	Who: ________
Muscle Disease	❑ No	❑ Yes	Who: ________
Psoriasis	❑ No	❑ Yes	Who: ________
Crohn's Disease or Ulcerative Colitis	❑ No	❑ Yes	Who: ________
Multiple Sclerosis	❑ No	❑ Yes	Who: ________
Cancer	❑ No	❑ Yes	Who: ________
Blood Disorders	❑ No	❑ Yes	Who: ________

Review of Systems

Do you have, or have you had in the past three months, any of the following (please check those you have experienced):

General
- ❑ Fever (over 100 degrees)
- ❑ Weight loss
- ❑ Night sweats
- ❑ Loss of energy
- ❑ Change in lymph nodes
- ❑ Snoring
- ❑ Trouble sleeping

Ears
- ❑ Ringing
- ❑ Loss of hearing

Eyes
- ❑ Trouble seeing
- ❑ Red or inflamed eyes
- ❑ Eye pain

Nose and Mouth
- ❑ Nose bleeds
- ❑ Mouth sores (ulcers, canker sores)
- ❑ Sinus pain
- ❑ Nasal congestion
- ❑ Nose bleeds

Neck
- ❑ Goiter
- ❑ Difficulty swallowing

Breasts
- ❑ Discharge from nipples
- ❑ Lumps

Cardiovascular
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Leg swelling
- ❑ Palpitations

Pulmonary
- ❑ Wheezing
- ❑ Cough
- ❑ Pain with breathing
- ❑ Cough up blood

Digestive
- ❑ Loss of appetite
- ❑ Heartburn
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Constipation

Genitourinary
- ❑ Burning on urination
- ❑ Bloody urine or discharge
- ❑ Difficulty urinating
- ❑ Urination at night, # of times___________
- ❑ Sexually transmitted diseases

Brain and Nerves and Muscles
- ❑ Seizures or epilepsy
- ❑ Dizziness
- ❑ Blackouts
- ❑ Weakness
- ❑ Stroke
- ❑ Headaches
- ❑ Depression
- ❑ Numbness
- ❑ Muscle pain

Blood
- ❑ Easy bruising
- ❑ Excessive bleeding

Skin
- ❑ Rashes
- ❑ Fingers changing color

Your Past Medical History

Please check those you have had:

- ❑ Polio
- ❑ Valley Fever
- ❑ Exposure to TB
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Hepatitis / Liver Disease
- ❑ Bladder Infections
- ❑ Kidney Disease
- ❑ Hay Fever
- ❑ Asthma
- ❑ Emphysema
- ❑ Back Trouble
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Stroke
- ❑ Anemia
- ❑ Bleeding Tendency
- ❑ Ulcer (stomach or intestine)
- ❑ Cancer
- ❑ Blood Transfusion
- ❑ Thyroid Disease
- ❑ Diabetes
- ❑ Mental Health Problem
- ❑ Epilepsy / Seizures
- ❑ Osteoporosis

Injuries or Accidents

- ❑ Head................ Year: ________
- ❑ Broken Bones................ Year: ________
- ❑ Other (please list): ________

Any work-related injuries (please list): ________

Operations (Check if Yes)

- ❑ Tonsils................ Year: ________
- ❑ Appendix................ Year: ________
- ❑ Gallbladder................ Year: ________
- ❑ Stomach................ Year: ________
- ❑ Breast................ Year: ________
- ❑ Uterus and/or Ovary................ Year: ________
- ❑ Prostate................ Year: ________
- ❑ Hernia................ Year: ________
- ❑ Thyroid................ Year: ________
- ❑ Varicose Veins................ Year: ________
- ❑ Hemorrhoid................ Year: ________
- ❑ Heart................ Year: ________
- ❑ Spine (back or neck)................ Year: ________
- ❑ Joint Replacement................ Year: ________
- ❑ Other (please list): ________