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RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE
(new rheum pt questionnaire)

Name: _____ Age:_____

Home Address: _____ Date of Birth: _____

City/State/Zip:_____ S.S.N.:_____

Home Phone:_____ Sex: [ ] Male [ ] Female

Work Phone: _____ Occupation:_____

Work address _____ Referring doctor _____

Cell phone_____

E mail _____

Date of Visit:_____

What is the reason you are here today?

In brief what is problem(s) you are here for today or have been diagnosed with already? What specific questions do you have and desire to be answered during this visit?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Doctors: (After filling in the information here please place a √ next to which of these you want this consultation note sent)
Primary Care (name, full address, phone, e mail address (important), fax):

_____

_____

_____

Specialists – list all doctors you see regularly for particular problems, such as a cardiologist, gastroenterologist, pulmonologist, psychiatrist
(name, full address, phone, e mail address (important), fax):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Personal History:

Occupation _____

If retired state when and whether it was for medical reasons_____

_____

If disabled, note when that happened and the reason for it_____

Are you married or do you have a partner? [ ] Yes [ ] No

Name: _____

How long have you been married or together_____

Do you have any children? [ ] Yes [ ] No

Names, ages and medical problems if they exist:

_____

_____

_____

_____

_____

Smoking:
Current smoker: [ ] Yes [ ] No
If yes, how much and how often? _____

Previous smoking: [ ] Yes [ ] No
If yes, when did you stop? _____

Alcohol use or drug habit:
How often, in what amounts and what type (beer, wine, etc)? Do you currently have or have you had an alcohol or drug problem?

_____

_____

Exercise:
Please describe how much and how often:

_____

_____

_____

Family History
Mother and Father: Alive, deceased (at what age and why?), illnesses

_____

_____

_____

Illnesses in children:

_____

_____

_____

Does anyone in your family have a history of the following musculoskeletal or autoimmune problems? The last rows are for other prominent medical problems in your family.

Illness	Family Member(s)	Manifestations	Treatment
Rheumatoid arthritis			
Systemic lupus erythematosus			
Mixed connective tissue disease			
Scleroderma			
Sjogren's syndrome			
Vasculitis			
Ankylosing spondylitis			
Psoriasis			
Psoriatic arthritis			
Uveitis			
Crohn's disease			
Reactive arthritis			
Osteoarthritis			
Osteoporosis			
Gout			
Pseudogout			
Other			

Infections: Have you had any of the following?

Infection	Yes	No	Date	How was it treated?	Symptoms?	Were you admitted to a hospital?
Rheumatic Fever						
Scarlet fever						
Tuberculosis						
Histoplasmosis						
Urine infection						
Pneumonia						
Lyme disease						
Urethritis						
Mononucleosis						
Diverticulitis						

Other infections: _____

_____

_____

Immunizations: Have you ever had any of the following immunizations?

Immunization	Yes/No. If yes, what year	Adverse Reaction, yes/no?	By mouth or injection?
Influenza			
HINI influenza			
Pneumovax			
Herpes Zoster (Zostavax)			
Hemophilus influenza			
Yellow fever			
Typhoid fever			
Measles			
Mumps			
Hepatitis A			
Hepatitis B			
Human Papillomavirus (HPV)			

Past surgeries

Surgery	Date of Surgery	Surgeon	Hospital	Complications

Current and prior medical problems

Please list any medical problems you currently have or have seen a doctor for in the past, e.g. high blood pressure, heart problems, peptic ulcer, thyroid problems. Please number (e.g. # 1 High blood pressure) and name each problem and also give the date of onset, duration, treatments, name and type of doctor.

Medical Problem	Date of Onset	Treatments	Doctor Involved	Hospitalizations?

MEDICATIONS:

*Please list **all**,* including **over-the counter drugs**, the doses, how often you take them, when you started them and what they were given for. Include pain medications. List vitamins and **herbal** or **alternative treatments** as well:

Name	Dose	How often is it taken?	What is it for?	When was it started?	Any side effects?

Other medications: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:

List drug name(s) and the type of allergic reaction (e.g., rash, difficulty breathing, etc), and any food or other allergies. State whether you have hives, asthma, hay fever, or have had desensitization shots

_____

_____

_____

_____

_____

_____

Have you had any of the following?

Symptom	Current	Ever	If current, describe
Psychiatric			
Depression			
Anxiety			
Sleep problems			
Constitutional			
Fatigue			
Fever			
Weight loss			
Malaise			
Ear, Nose Throat			
Sneezing			
Loss of smell			
Bloody from nose			
Dry Mouth			
Red or painful eyes			
Ear pain			
Hearing loss			
Scalp tenderness			
Red ear			
Skin			
Rash			
Psoriasis			
Hair loss			
Raynaud's phenomenon (finger color change from white to blue to red)			
Skin tightness			
Lungs			
Cough			
Chest pain with breathing (pleurisy)			
Coughing up blood			
Shortness of breath			
Heart			
Chest pain			
Palpitations			
High blood pressure			
Abdomen			
Abdominal pain			
Diarrhea			
Blood in the stool			

Symptom	Current	Ever	If current, describe
Genitourinary			
Burning on urination			
Frequency of urination			
Blood in urine			
Foamy urine			
Neurologic			
Headache			
Migraine			
Weakness			
Numbness or tingling			
Seizures			
Stroke			
Eyes			
Double vision			
Red or painful eyes			
Loss of vision			
Blurred vision			
Hematology			
Easy bruising			
Bleeding disorder			
History of hemophilia			
Allergy			
Asthma			
Anaphylaxis			
Hayfever			
Hives			
Endocrine			
Diabetes			
Thyroid disease			
High calcium			

Health Maintenance/cancer assessments:

For women:

When was your last pap smear? _____

Have you ever had an abnormal pap smear? [ ] Yes [ ] No

When was your last mammogram?_____

When was your last pelvic exam?_____

For men:

Have you ever had an abnormal prostate test (PSA) or prostate problem? [ ] Yes [ ] No

_____

For both:

When was your last rectal examination? _____

Have you ever had a colonoscopy? [ ] Yes [ ] No If yes, when? _____

When was your last internal medicine, primary care assessment?_____

Please write down any other concerns you would like to bring up during the visit:

_____

_____