Rheumatology New Patient History Form

Today's date ____/____/_____ Patient Name_____ Age_____
MO DAY YR LAST FIRST MI

Birthdate ____/____/_____ Sex_____ Ethnics (optional) _____ Occupation _____
MO DAY YR M/F

Address_____
STREET APT# CITY STATE ZIP

Telephone One_____ Telephone Two_____
Check ◻ HOME ◻ WORK ◻ MOBILE Check ◻ HOME ◻ WORK ◻ MOBILE

Referred by _____ who is ◻ Self ◻ Family ◻Friend ◻ Physician ◻ Others

Primary Care Physician _____ Location _____

Reason for present visit _____

_____

Date symptoms began_____

Location of pain_____(Mark on the diagrams)

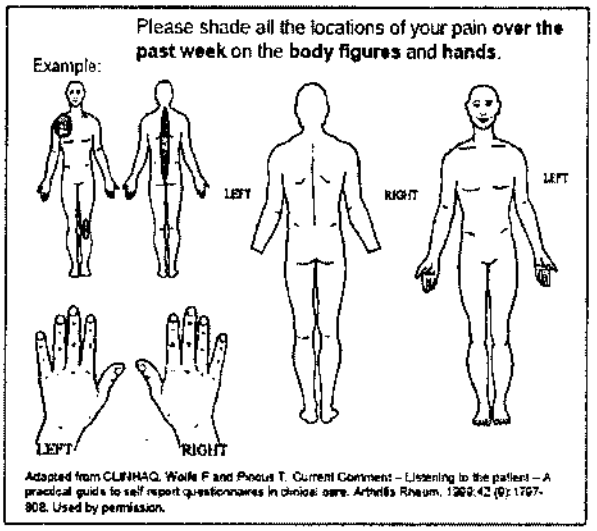
Level of pain on a scale of 1-10_____

Worsening factors_____

Any diagnosis given_____

Any Treatment _____

_____



Adapted from CLINHAQ. Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Rheumatologic History:

Diseases	Yourself	Relative Name/Relationship
Rheumatoid Arthritis		
Osteoarthritis		
Lupus or "SLE"		
Ankylosing Sondylitis		
Childhood arthritis		
Others:		

Other Medical Problems (check if "Yes")

◻ High blood pressure	◻ Anemia	◻ Stomach ulcer	◻ Glaucoma	◻ Cancer
◻ Heart problems	◻ Kidney disease	◻ Hepatitis	◻ Cataracts	◻ Tuberculosis
◻ Diabetes	◻ Emphysema	◻ Jaundice	◻ stroke	◻ HIV/AIDS
◻ High cholesterol	◻ Pneumonia	◻ Goiter	◻ Epilepsy	◻ Fractures
◻ Others (Specify)				

Previous Operations

Type	Year	Reason

Family History

Number of siblings _____ #Living ____ #Deceased ____; Number of children _____ # Living ____ #Deceased _____

Any rheumatic diseases in the family, who and what _____

Patient's name _____ **Chart#** _____ **Date** _____ **MD Initials**_____

Sherri Zhu, MD 2/2006

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	Age If Living	Health	Age at death if deceased	Cause
Father				
mother				

Do you smoke? □ Yes □ No □ Past --- How long ago? _____ Number per day _____, for how long _____

Do you drink alcohol? □ Yes □ No If yes, what kind _____ Number per week_____

Do you use drugs not for medical reasons? □ Yes □ No If yes, please list _____

Drug Allergies: □ Yes □ No To what _____

Type of reaction _____

Current Medications

Name of Drug	Strength	Frequency	For how long
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Attached a List or write at the back of this page if more space is needed.

Systems Review

Date of last eye exam ___/___/___ Date of last chest x-ray ___/___/___ Date of last Tuberculosis Test ___/___/___

Please check any of the following problems listed, which have significantly affected you.

Constitutional
□ Recent weight gain, amount ____
□ Recent weight loss, amount ____
□ Fatigue □ Fever
□ Weakness

Eyes
□ Pain □ Redness
□ Itching
□ Dryness □ Loss of vision
□ Double or blurred vision
□ Feel like something in the eye

Ears-Nose-Mouth-Throat
□ Ringing in ears
□ Loss of hearing
□ Nosebleeds □ Loss of smell
□ Sore tongue □ Bleeding gum
□ Sores in mouth
□ Dryness in mouth
□ Difficulty in swallowing

Cardiovascular
□ Pain in chest
□ Heart murmurs
□ Irregular heart beat
□ Congestive heart failure

Respiratory
□ Shortness of breath
□ Difficulty in breathing at night
□ Cough □ Wheezing
□ Coughing of blood

Gastrointestinal
□ Nausea □ Vomiting
□ Stomach pain/heart burn
□ Increasing Constipation
□ Frequent Diarrhea
□ Blood in stools or black stools

Genitourinary
□ Difficult urination
□ Pain or burning on urination
□ Blood or pus or cloudy urine
□ Rash or ulcers
□ Discharge from penis/vagina
□ Sexual difficulties

For Women only
Date of last period ___/___/_____
Date of last pap ___/___/_____
Number of pregnancies _____
Number of miscarriages _____
Age when period began _____
Periods regular? □ Yes □ No
How many days apart_____

Skin and breast
□ Redness □ Hives □ Rash
□ Sun allergy □ Tightness
□ Nodules/bumps □ Hair loss
□ Color changes of hands or feet in the cold

Neurological
□ Severe Headaches □ Dizziness
□ Passed out □ Memory loss
□ Sensitivity or pain of hands/feet
□ Restless legs at night
□ Night sweats

Psychiatric
□ Anxiety □ Depression
□ Agitation □ Difficulty of sleep

Others
□ Swollen/tender glands
□ Bleeding tendency
□ Transfusion, when_____
□ Frequent infection
□ Excessive thirst

Musculoskeletal
□ Morning stiffness How long____
□ Muscle tenderness □ Weakness
□ Joint swelling/pain
List joints affected in the last 6 mos.
_____
_____
_____
_____
_____

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Patient Assessment

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well ├──────────────────────────────────────┤ Very Poorly

How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain ├──────────────────────────────────────┤ Pain as Bad as It Could Be

Please answer the following questions, even if you feel that they may not be related to you at this time. Answer exactly as you think or feel – there are no right or wrong answers. Check the one best answer for each question.

Activity Level **Right now, are you able to:**	**Without any difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
2. Get in and out of bed?	0	1	2	3
3. Lift a full cup or glass to your mouth?	0	1	2	3
4. Walk outdoors on flat ground?	0	1	2	3
5. Wash and dry your entire body?	0	1	2	3
6. Bend down to pick up clothing from the floor?	0	1	2	3
7. Turn regular faucets on and off?	0	1	2	3
8. Get in and out of a car, bus, train or airplane?	0	1	2	3
9. Walk two miles?	0	1	2	3
10. Participate in sports and games as you like?	0	1	2	3
11. Get a good night's sleep?	0	1.1	2.2	3.3
12. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
13. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

For Office Use Only

GL ☐

PN ☐

FN ☐

1=0.33
2=0.67
3=1.0
4=1.33
5=1.67
6=2.0
7=2.33
8=2.67
9=3.0
10=3.33
11=3.67
12=4.0
13=4.33
14=4.67
15=5.0
16=5.33
17=5.67
18=6.0
19=6.33
20=6.67
21=7.0
22=7.33
23=7.67
24=8.0
25=8.33
26=8.67
27=9.0
28=9.33
29=9.67
30=10.0

Your Name_____ **Today's Date**_____ **Time of Day** _____

Instructions for Office Staff

Activity Level Index Scoring: For FN (questions 1-10) add total points and convert using scale on right. For PS (questions 11-13), add total points.

Visual Analog Scales: measure with metric ruler. Line is exactly 10 cm long. Scores should be recorded in cm.mm format.

Adapted from
Pincus T, Swearingen C, Wolfe F. Toward a Multidimensional Health Assessment Questionnaire. Arthritis Rheum 1999; 42:2220-2230.