Rheumatology & Arthritis consultants

NEW PATIENT HISTORY FORM

CURRENT SYMPTOMS

Describe briefly your present symptoms: _____
_____
_____

Date symptoms began (approximate): _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):_____
_____
_____

OTHER HEALTHCARE PROVIDERS

Please list the names of other practitioners you have seen for this problem: _____

Name of Referring Physician (if applicable):_____ Name of Primary Care Physician:_____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____
Name of local pharmacy:_____ Name of Mail Order Pharmacy:_____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____
Type of reaction: _____

Present Medications (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium, and other supplements, etc.)

	Name of Drug	Dose (include strength & number of pills per day)	How long have you been taking this medication?	Please check: Helped? A Lot	Some	Not At All
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐

VACCINE HISTORY (if applicable)

Date of last flu shot:_____ Date of last pneumonia vaccine:_____

Date(s) of Covid Vaccine: #1 _____ #2_____ #3_____ Manufacturer:_____

HEALTH MAINTENANCE

Date of last mammogram _____ Date of last bone densitometry & at which facility _____

Date of last eye exam _____ Date of last chest x–ray _____ Date of last colonoscopy _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative/ Name Relationship	Yourself		Relative/ Name Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
	Sarcoidosis			Psoriasis	
	Cystic Fibrosis			Celiac Disease	
	Ulcerative Colitis			Chron's Disease	
	Vasculitis			Recurrent Infections	
Other arthritis conditions:					

Patient Name:_____ ***Date:***_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____
Number of children _____ Number living _____ Number deceased _____ List ages of each _____
Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer	☐ Epilepsy	☐ Bleeding tendency
☐ Leukemia	☐ Tuberculosis	☐ Alcoholism
☐ Heart disease	☐ Diabetes	☐ Asthma
☐ High blood pressure	☐ Stroke	☐ Psoriasis
☐ Rheumatic fever	☐ Colitis	☐ Goiter

EDUCATION (circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____
Occupation _____ Number of hours worked/average per week_____

SOCIAL HISTORY
Tobacco Screening
Do you smoke? ☐ Yes ☐ No ☐ Former How many years have you smoked tobacco?_____
At what age did you start smoking tobacco? _____ How much do you smoke? _____
Do you or have you ever used any other forms of tobacco or nicotine? ☐ Yes ☐ No
Do you or have you ever used e-cigarettes or vape? ☐ Yes ☐ No
Do you or have you ever used smokeless tobacco? ☐ Yes ☐ No
How much tobacco do you chew? _____

Alcohol / Drug Screening
What is your level of alcohol consumption? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you use any illicit or recreational drugs? ☐ Yes ☐ No If yes, please list: _____

What is your level of caffeine consumption? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

What is your relationship status? ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Other

What is your exercise level? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

Do you have an advanced directive? ☐ Yes ☐ No

How many hours of sleep do you get at night? _____ Do you get enough sleep at night? ☐ Yes ☐ No

SURGICAL HISTORY

	Type	***Year***	***Reason***
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ☐ No ☐ Yes Describe: _____
Any other serious injuries? ☐ No ☐ Yes Describe: _____

Patient Name:_____ ***Date:_____***

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- ☐ Anemia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis (unknown type)
- ☐ Asthma
- ☐ Bad headaches
- ☐ CHF
- ☐ COPD
- ☐ Cancer
- ☐ Cataracts
- ☐ Celiac Disease
- ☐ Coronary Artery Disease
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD / Reflux
- ☐ Glaucoma
- ☐ Pneumonia
- ☐ Multiple Sclerosis
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Gout
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver Disease
- ☐ Lupus or SLE
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Embolism/ DVT
- ☐ Recurrent Infections
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Sjogren's Syndrome
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcerative Colitis/ Chron's Disease
- ☐ Vasculitis
- ☐ Leukemia

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

FOR WOMEN ONLY:

Date of last mammogram: _____ ____

Do you currently have monthly periods? ☐ No ☐ Yes

Age at time of first period? _____

Age at menopause? (if applicable) _____

Current birth control method (if applicable) _____

Number of pregnancies? _____

Number of miscarriages? _____

***Patient Name:*_____** ***Date:*_____**