Contact Phone Number: Home ___ ____ ____**; Cell** ___ ____ ____**;**

Name of referral physician: _____

Pharmacy: Name:_____ **phone** ___ ____ ____

What is your main concern to address for this visit: _____

_____;

Dates the symptoms began _____; major associated symptoms _____

_____;

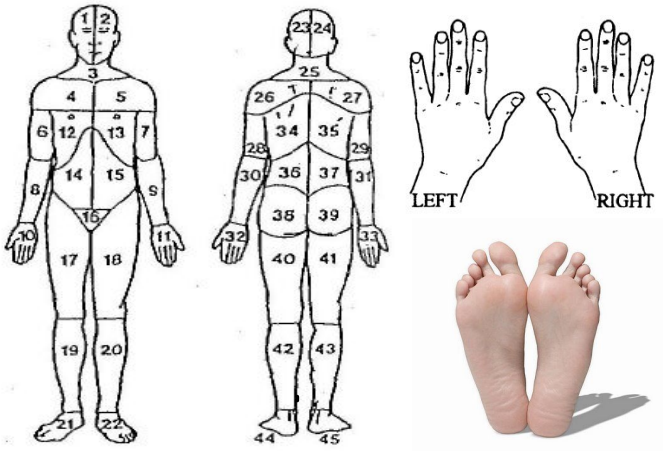
previous rheumatologic evaluation: No ___ ; Yes ___, by Dr._____, diagnosis_____,

previous treatments: medications _____,

physical therapy: No ___, Yes ___ ; surgical operation: No ___, Yes ___ (what surgery ?_____),

Injections: No___, Yes ___ by Dr. _____, what type of inections ? _____.

Please shade the area where you have pain in the last week.



Mark the following medical conditions that apply to you and family members.

	You	Dad	Mom	Siblings	Blood relatives
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Ankylosing spondylitis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Lower back pain	☐	☐	☐	☐	☐
Blood clots/DVT	☐	☐	☐	☐	☐
Bleeding problem	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐

Your Past Medical History

- ☐ Inflammatory eye diseases
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Sjogren's syndrome
- ☐ Thyroid diseases
- ☐ COPD/Emphysema
- ☐ Pneumonia
- ☐ Asthma
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Stroke
- ☐ Seizure disorders
- ☐ Peripheral neuropathy
- ☐ Myopathy
- ☐ GERD/Acid reflex
- ☐ GI bleeding
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Anemia
- ☐ Hepatitis
- ☐ HIV
- ☐ STD
- ☐ Cancer/Leukemia
- ☐ Migraines
- ☐ Major depression
- ☐ Fracture: location ____

Past Surgical History **Date**

- ☐ Knee replacement
- ☐ Hip replacement
- ☐ Rotator cuff repair
- ☐ Carpal tunnel release
- ☐ Cervical spine surgery
- ☐ Lumbar spine surgery
- ☐ Knee arthroscopy
- ☐ Vasectomy
- ☐ Tubal ligation

Past Procedural History **Date**

- ☐ Pulmonary function test PFT
- ☐ 2D-Echocardiogram
- ☐ Chest CT
- ☐ Heart Catheterization
- ☐ Stress test
- ☐ EMG/NCS
- ☐ Muscle biopsy
- ☐ Skin biopsy

Health Maintenance

Name of your primary Care Physician: _____
Name of Rheumatologist: _____
Your other subspecialists: _____

Date

- ☐ Flu vaccine _____
- ☐ Pneumonia vaccine _____
- ☐ Shingles vaccine _____
- ☐ Tuberculosis test _____

Date

- ☐ Bone densitometry _____
- ☐ Colonoscopy _____
- ☐ Mammogram _____
- ☐ PAP Smear _____

Other family medical history (other than that you checked on page 1):_____;

Social History

Single / Married / Divorced
Number of children _____
Occupation _____

Alcohol consumption: No __, Yes, ___drinks/d
Smoking: No __; quit___yr; Yes ___ pack /week
Cocaine/other Illicit drug use: No __, Yes __

Sleep: fair __, poor: initiation ___, maintenance___
feel rested in Am ? Yes __, No __
Caffeine (cups/d) _____
Exercises (type/hr/wk) _____

Pregnancy: Number of pregnancies ____; Number of live children____; Miscarriages ____; Complication of pregnancy: _____

Are you currently pregnant: No__, Yes__ ; Are you planning to have a child: No__, Yes__; Method of contraception _____

Travel History: Have you attracted any disease from traveling? No__, Yes: where_____, what disease?_____;
Have you had tick bites with skin rash ? No___, Yes___

Drug Allergy: (drug names and reactions): _____;

Medications you are currently taking

Name of Medications	Duration	Dose	Frequency	Name of medications	Duaration	Dose	Frequency

Mark the medications you took before		Duration	Helped?		Duration	Helped?
NSAIDs	Ansaid (Flutiprofen)		Y / N	Meclomen (Meclofenamate)		Y / N
	Arthrotec (Diclofenac + misoprostil)		Y / N	Motrin/Rufen (Ibuprofen)		Y / N
	Celebrex (Celecoxib)		Y / N	Nalfon (Fenoprofen)		Y / N
	Clinoril (Sulindac)		Y / N	Naprosyn (Naproxen)		Y / N
	Daypro (Oxaprozin)		Y / N	Oruvail (Ketoprofen)		Y / N
	Disalcid (Salsalate)		Y / N	Tolectin (Tolmetin)		Y / N
	Dolobid (Diflunisal)		Y / N	Trilisate (Choline magnesium trisalicylate)		Y / N
	Feldene (Piroxicam)		Y / N	Vioxx (Rofecoxib)		Y / N
	Indocin (Indomethacin)		Y / N	Voltaren (Diclofenac)		Y / N
	Lodine (Etodolac)		Y / N			
Pain Medications						
	Tylenol (Acetaminophen)		Y / N	Lortab (hydrocodone/acetaminophen)		Y / N
	Tramadol (Ultram)		Y / N	Fentanyl patch (Duragesic)		Y / N
	Tylenol # 3 (codeine/acetaminophen)		Y / N	MS Contin		Y / N
	Fioricept		Y / N	Oxycodone		Y / N
	Talwin NX		Y / N	Methadone		Y / N
Disease Modifying Antirheumatic Drugs (DMARDs)						
	Ridaura (Auranofin, gold pills)		Y / N	Imuran (Azathioprine)		Y / N
	Gold shots (myochrysine or solganol)		Y / N	Arava (Leflunomide)		Y / N
	Plaquenil (Hydroxychloroquine)		Y / N	Sandimmune, Neoral (Cyclosporine A)		Y / N
	Cuprimine (Penicillamine, Depen)		Y / N	Cellcept (Mycophenolate mofetil)		Y / N
	Rheumatrex (Methotrexate)		Y / N	Cytoxan (Cyclophosphamide)		Y / N
	Azulfidine (Sulfasalazine)					
Biologics						
	Humira (Adalimumab)		Y / N	Rituxan (Rituximab)		Y / N
	Enbrel (Etanercept)		Y / N	Actemra (Tocilizumab)		Y / N
	Remicade (Infliximab)		Y / N	Orencia (Abtacept): infusion __ injection __		Y / N
	Simponi (Golimumab)		Y / N	Benlysta (Belimumab)		Y / N
	Cimzia (Certolizumab)		Y / N	Prolia (Denosumab)		Y / N
Osteoporosis						
	Fosamax (Alendronate)		Y / N	Boniva (Ibandronate)		Y / N
	Actonel (Risedronate)		Y / N	Reclast (Zoledronic acid)		Y / N
Gout						
	Allopurinol (Zyloprim/Lopurin)		Y / N	Colcrys (Colchicine)		Y / N
	Uloric (Febuxostat)		Y / N	Benemid (Probenecid)		Y / N

Have you participated in any rheumatolog clinical trials: No __, Yes: dates _____, drug _____,
rheumatologist Dr._____ , Location _____.

Please check the symptoms you had in the past week.

Review of Systems

General:	Weight gain (lb ?)	Y / N	Fatigue	Y / N
	Weight loss (lb ?)	Y / N	Appetite	Y / N
	Fever	Y / N	Morning stiffness	Y / N
	Night sweats	Y / N		
Skin	Facial rash	Y / N	Hair loss	Y / N
	Rash with skin ulcers	Y / N	Nail dimpling	Y / N
	Skin rash	Y / N	Hardening/tightness	Y / N
	Nodules/bumps	Y / N	Hypersensitivity to sun light	Y / N
	Purple / white fingers/toes	Y / N		
HEENT	Double vision	Y / N	Loss of ear cartilage	Y / N
	Blurry vision	Y / N	Hearing loss	Y / N
	Red eyes	Y / N	Sinus problems	Y / N
	Dry eyes	Y / N	Voice change	Y / N
	Eye pain	Y / N	Choking	Y / N
	Dry mouth	Y / N	Sore throat	Y / N
	Oral ulcers	Y / N	Gum bleeding	Y / N
Neck	Neck pain	Y / N	Thyroid nodules	Y / N
	Stiffness	Y / N	Mass	Y / N
Respiratory	Shortness of breath	Y / N	Wheezing / Asthma	Y / N
	Cough	Y / N	Hemoptysis/cough up blood	Y / N
Breast	Mass	Y / N	Color change	Y / N
	Retraction	Y / N		
Heart	Chest pain	Y / N	Leg swelling	Y / N
	Irregular heart beat	Y / N	Fainting	Y / N
Gastrointestinal	GERD/ acid reflex	Y / N	Constipation	Y / N
	Difficulty in swallowing	Y / N	Diarrhea	Y / N
	Bloody stool	Y / N	Colitis	Y / N
Genitourinary	Bloody urine	Y / N	Rash	Y / N
	Discharge	Y / N	Ulcers	Y / N
Musculoskeletal	Joint pain	Y / N	Joint deformity	Y / N
	Joint swelling	Y / N	Muscle weakness	Y / N
	Stiffness	Y / N	Muscle cramp	Y / N
	Unable to extend wrists or feet	Y / N	Muscle pain	Y / N
Neurological	Tingling/numbness	Y / N	Headaches	Y / N
	Loss of gait balance	Y / N	Frequent falls	Y / N
	Tremor	Y / N		
	Seizure	Y / N		
Psychiatric	Depression	Y / N	Sleeping disorders	Y / N
	Anxiety	Y / N	Psychosis	Y / N
Endocrine	Cold intolerance	Y / N	Diabetes	Y / N
	Heat intolerance	Y / N	Adrenal insufficiency	Y / N
Hematology	Anemia	Y / N	Swollen/ tender glands	Y / N
	Easy bruising/ bleeding	Y / N	Cancer / leukemia	Y / N