SOUTHVIEW RHEUMATOLOGY NEW PATIENT FORM

Name:___________________________________

DOB:___________________________________

Email:__________________________________

Primary Care Physician/Clinic:____

Pharmacy and Location:____

HPI

What are you here for today? Please briefly describe your present symptoms.

____
____
____

When did your symptoms begin?

____

Have you seen any other physician for this problem? If so, who?

____
____

Please list any previous treatment you have received for this problem:

____
____

When you wake up in the morning, are your joints stiff? [ ] Yes or [ ] No

If yes, for how many minutes? ____

Past Medical History

Have you had any of the following illnesses? (Check please)

Diabetes ("sugar")		Heart Failure (CHF)		Depression/Anxiety	
High Blood Pressure		Thyroid Problems		Anxiety	
High Cholesterol		Seizures		Seasonal Allergies	
Asthma		Headaches/Migraines		Psoriasis	
COPD		Kidney Problems		Chronic Rashes	
Stroke		Liver Problems		Fibromyalgia	
Heart Attack		Cancer		Reflux (Heartburn)	
Obstructive Sleep Apnea		Osteoarthritis		Osteoporosis	

Please list any other medical conditions that you are being treated for:

____
____
____
____

Vaccination

Do you get an annual flu shot? [ ] Yes or [ ] No IF no, why not? _______________________________

Have you ever received the pneumonia vaccine? [ ] Yes or [ ] No IF yes, when? ___________________

Have you ever received the zoster/shingles vaccine? [ ] Yes or [ ] No IF yes, when? ________________

Have you ever received any other vaccines as an adult? If so, please list __________________________

Surgical

Please list any surgeries (especially joint surgery) you have had:

____
____
____
____

Medications

Please list any medicines including supplements that you are currently taking (or bring a list with you). Please include strength and directions for taking:

____
____
____
____

Drug Allergies

Please list any medicines that you are allergic to:

____
____

Social History

Do you smoke? [ ] Current smoker [ ] Former smoker [ ] Nonsmoker

If you are current smoker, how often and how much do you smoke? __________________________

Do you drink alcohol? [ ] Yes [ ] No ; If yes: [ ] daily [ ] socially [ ] rarely ; If daily, how many drinks? _____

Do you exercise? [ ] Yes [ ] No ; If yes, what do you do and how often? ____________________________

How is your sleep at night? [ ] Good [ ] Fair [ ] Poor

Do you snore? [ ] Yes [ ] No

Do you have trouble getting to sleep? [ ] Yes [ ] No ; If yes, why?_________________________________

Do you awaken during the night? [ ] Yes [ ] No ; If yes, why? ____________________________________

How many hours do you sleep at night? ________ Do you wake up feeling Tired? [ ] Yes [ ] No

Marital Status

Please *circle* the appropriate answer: Married Single Divorced Separated

How many people reside in the home with you? ____

Please list them:

____

____

____

What are your hobbies? How do you manage stress?

____

____

____

Employment type

Please *circle* the appropriate answer: Full Time Part Time Retired Disabled

If employed, what is your occupation?

____

____

Family History

Have any of your family members been diagnosed with any of the following diseases? If so, please list how they are related to you (ie mother, father, sibling, aunt, etc).

[ ] Arthritis (type unknown) _____________________ [ ] Gout _______________________________

[ ] Osteoarthritis _________________________________ [ ] Osteoporosis ________________________

[ ] Rheumatoid arthritis ___________________________ [ ] Ankylosing Spondylitis ________________

[ ] Systemic Lupus Erythematosus __________________ [ ] Crohn's/ Ulcerative Colitis ______________

[ ] Myositis ______________________________________

[ ] Psoriasis ______________________________________

Please list any other medical illnesses in your family:

____

____

Review of Systems

Please circle any symptoms that pertain to you:

Constitutional: Fevers / chills / fatigue / weight change / night sweats / insomnia / NONE

Eyes: Dry eyes / visual loss / blurred vision / contacts / glasses / tearing / NONE

ENT: Dry mouth / mouth sores / no sores / dental pain / NONE

Cardio: Racing heart / chest pain / chest pressure / pericarditis by history / NONE

Pulm: Shortness of breath / wheezing / cough / painful breathing / NONE

GI: Nausea or vomiting / diarrhea / heartburn / bloody stools / difficulty or painful swallowing / NONE

Skin: Rashes / dry skin / scaling skin / hair loss / rashes with sun exposure / discolorations of hands with cold exposure / NONE

Neuro: Numbness or tingling in arms and legs / headaches / weakness / NONE

Bone Health (Both men and women, please complete this below)

Have you ever had a bone density exam? [ ] Yes [ ] No. If yes, when was your last exam? ______________

If you are a woman , have you gone through menopause? [ ] Yes [ ] No. If yes, when? ________________

Do you take calcium supplementation? [ ] Yes [ ] No. If yes, how much? ____________________________

Do you take Vitamin D supplementation? [ ] Yes [ ] No. If yes, how much? __________________________

Have you ever had a fracture or broken bone? Please list: ____

Do you have any history of kidney stones? [ ] Yes [ ] No. If yes, when? ______________________________

Do you have any history of cancer/radiation? [ ] Yes [ ] No. If yes, when? ___________________________