

Rheumatology | New Patient Systems Review & Medical Profile

Name: _____ Date of birth: _____ Today's Date: _____

Reason for this appointment: _____

Describe symptoms: _____

When did symptom(s) start? _____

Have you seen others for this Rheumatologic problem? No Yes If yes who? _____

Any previous treatment for this problem? No Yes If yes, explain (include physical therapy, surgery, injections, (medications to be listed separately below) _____

Last Plaquenil eye exam and where? _____

Occupation: _____ Average number of hours work per week: _____ Retired Yes No

As you review the following, please check any of those problems which apply to you:

GENERAL	EYES	HEART & LUNGS
Allergies	Blurred vision	Atrial fibrillation
Environmental Allergies	Double vision	Cough
Fatigue	Dryness	Coughing of blood
Fever	Eye inflammation	Difficulty in breathing at night
Night sweats	Light sensitivity	Heart failure
Recent weight gain – amount:	Pain	Heart murmurs
Recent weight loss – amount:	Redness	Heart of vessel stents
Sleep disturbances	Vision loss	High blood pressure
EARS	HANDS / FEET	History of fluid in lung
Ear drainage	Nail damage	History of heart attack
Ear pain	Loss of sensation in hands or feet	History of Pericarditis
Hearing aids	Swollen legs or feet	History of stroke
Hearing loss	Swollen toes	Irregular heartbeat
Ringing of ears/tinnitus	Plantar Fasciitis	Pain in chest
Sudden hearing loss	SKIN	Palpitations or fluttering
FACE	Blisters	Pleurisy
Tongue pain	Color changes of hands/ feet in cold	Pneumonia
Jaw pain	Dryness	Pulmonary embolism (blood clot in lungs)
MOOUTH	Easy bruising	Shortness of breath
Change in tastes	Hair loss	Sudden change in heartbeat
Dentures	Hardening of skin	Wheezing
Difficulty swallowing	Hives	NERVOUS SYSTEM
Dry mouth	Nodules/bumps	Dizziness
Hoarseness	Rash	Fainting
Loss of voice	Rash from sun	Headache
Mouth sores	Redness	Loss of balance
Sore throat	Scalp pain	Loss of consciousness
Swollen glands	Sores or ulcers in skin	Loss of control of movement
NOSE	Sun sensitive (sun allergy)	Memory loss
Dryness	Tick bite in the last 5 years	Muscle spasm
Nasal congestion	Tightness	Numbness or tingling sensation in limbs
Nasal ulcers	INFECTIONS	Tremors
Nosebleeds	Persistent Infections	STOMACH AND INTESTINES
Sinus drainage or congestion	Recent Infections	Acid reflux
Sores in nose	Other:	Vomiting
	LYMPH NODES	Abdominal pain
	Swollen Lymph Nodes	

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BLOOD	PSYCHIATRIC	MUSCLES/JOINTS/BONES (continued)
Bleeding tendency	Mood changes	Joint redness
Blood clots/ phlebitis	Other	Joint replacement
Low platelet count	LIFESTYLE	Joint swelling
HIV Exposure	Drink caffeine	Loss of range of motion
URINE/BLADDER	Drink alcohol How much/day	Morning stiffness lasting how long?
Pain or burning on urination	Current smoker How much/day	Muscle cramps
Blood in urine	Past smoker How much/day	Muscle pain
Loss of bladder or bowel control	E-Cigarettes How much/day	Muscle tenderness
Genital rash	Cigars How much/day	Muscle weakness
Rectal sores or fissures	Smokeless tobacco How much/day	Neck pain
STOMACH AND INTESTINES	Use street drugs? How often and list	Pain at night
Blood in stools / Black stools	1	Shingles
Heartburn	2	Tendonitis
Increasing constipation	MUSCLES/JOINTS/BONES	Trouble standing
Mucus in stools	Back pain	Trouble walking
Nausea	Broken bones/fractures	List joint affected in the last 6 months:
Persistent diarrhea	Gout flare	1
Ulcers	Joint dislocation	2
	Joint pain	3

DISEASE HISTORY - To the best of my knowledge, at any time have you or a blood relative had any of the following? (Check if 'Yes')								
Diagnosis	You	Relative	Diagnosis	You	Relative	Diagnosis	You	Relative
Anemia			Fibromyalgia			Osteoarthritis		
Ankylosing Spondylitis			Gastric Ulcer			Osteoporosis		
Anxiety			GERD			Peptic Ulcer		
Arthritis			Gout			Pericarditis (History of)		
Asthma			Hashimoto's Thyroiditis			Psoriasis/Psoriatic Arthritis		
Blood clots/ phlebitis			Heart Murmur			Rheumatoid Arthritis		
Cancer			Heart Problems			Seizures		
Celiac disease			Hepatitis			Shingles		
Childhood Arthritis			High Blood Pressure			Sjogren's Syndrome		
Chronic Lung Disease			High Cholesterol			Spondylarthritis		
Chronic lung disease			Hypothyroidism			Temporal arteritis		
COPD			Iritis or Uveitis			Thyroid disease		
Crohn's disease			Kidney Disease			Ulcerative colitis		
Depression			Liver disease			Vasculitis		
Diabetes Type I			Lupus or "SLE"			Other		
Diabetes Type II			Multiple Sclerosis			Other		

PREVIOUS FRACTURES			
Any previous fractures:	No	Yes	Describe:

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PREVIOUS SURGERIES			
Type	Year	Type	Year
1.		3.	
2.		4.	
Any previous fractures: No Yes Describe: _____			

PAST MEDICATIONS						
As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the effectiveness of the medication, and any reactions you have had.						
Drug Name	Dosage	Length of Time on Medication	Please rate how effective			Reactions
			Not at all	Some	Very	
Arava (Leflunomide)						
Azulfidine/Sulfasalazine						
Cortisone/Prednisone						
Cytoxan/Cyclophosphamide						
Enbrel						
Gold (shots or pills)						
Humira						
Methotrexate						
Plaquenil/hydroxychloroquine						
Remicade						
Rinvoq						
Xeljanz						
Other						
Drug allergies? No Yes Describe: _____						

CURRENT MEDICATIONS (Or bring a medication list)				
Medication Name	Dosage	Frequency	Diagnosis	Prescribing physician
Include all prescription and non-prescription drugs, vitamins, and supplements	Include mg, mcg, units, puffs, drops	How many times per day? After meals? At bedtime?	For what reason is this medication being	Who is prescribing this medication for you?

To assist us in meeting your needs today, please answer the following questions.

Name: _____ DOB: _____ Date: _____

Since my last visit, I'm doing: Very Well Well Fair Poor Very Poor

Compared to my last visit here, I'm doing: Same Better Worse

What bothers you most today? _____

Please check the areas below that are bothering you most today.

On a scale of 0-10, with 0 being no pain and 10 being extreme pain, how much pain are you in?

0 1 2 3 4 5 6 7 8 9 10

How long is your morning stiffness? (check the box)

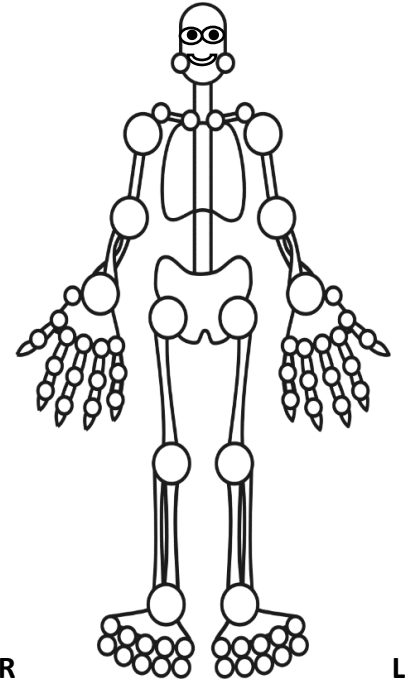
None <10min 15min 30min 45min 1hr 2hr 4hr All day

Describe your night-time sleep: (check the box)

Great Normal Fair Poor Very Poor Can't Fall Asleep
Can't Stay Asleep Wake Early Snoring Restless Legs Night Pain

Since last visit, I've had:

No Problems
Falls / Injuries _____
New Diagnosis _____
Infection _____
Surgery _____
Hospitalization _____



If you are taking Hydroxychloroquine (Plaquenil), when was your last Hydroxychloroquine specific Eye Exam? _____ Where was it completed? _____