Holland Hospital
PHYSICIAN OFFICES

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)
MOUTH	☐ 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	☐ Tendinitis
☐ Heartburn	2	☐ Trouble standing
☐ Increasing constipation	MUSCLES/JOINTS/BONES	☐ Trouble walking
☐ Mucus in stools	☐ Back pain	☐ List joint affected in the last 6 months:
☐ Nausea	☐ Broken bones/fractures	
☐ Persistent diarrhea	☐ Gout flare	
☐ Ulcers	☐ Joint dislocation	
	☐ Joint pain	

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	☐	☐	Gastric Ulcer	☐	☐	Osteoporosis	☐	☐
Ankylosing Spondylitis	☐	☐	GERD	☐	☐	Peptic Ulcer	☐	☐
Anxiety	☐	☐	Gout	☐	☐	Pericarditis (History of)	☐	☐
Arthritis	☐	☐	Hashimoto's Thyroiditis	☐	☐	Psoriasis/Psoriatic Arthritis	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatoid Arthritis	☐	☐
Blood clots/ phlebitis	☐	☐	Heart Problems	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Shingles	☐	☐
Celiac disease	☐	☐	High Blood Pressure	☐	☐	Sjogren's Syndrome	☐	☐
Childhood Arthritis	☐	☐	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	☐	☐
Fibromyalgia	☐	☐	Osteoarthritis	☐	☐		☐	☐

PREVIOUS FRACTURES

Any previous factures: ☐ No ☐ Yes Describe:

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PREVIOUS SURGERIES	
Type Year	Type Year
1.	3.
2.	4.
Any previous factures: ☐ 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? _____

_____

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 _____

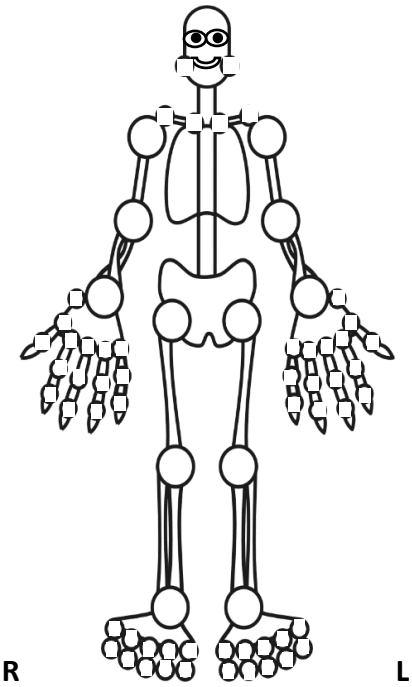
☐New Diagnosis _____

☐Infection _____

☐Surgery _____

☐Hospitalization _____

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



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