

Rheumatology

NEW PATIENT HISTORY FORM

Patient Information

Today's date: _____

Last name: _____ First name: _____ M.I.: _____

Date of birth: _____ Age: _____ Sex assigned at birth: ☐ Female ☐ Male

Address: _____

City: _____ State: _____ ZIP: _____

Mobile phone: _____ Home phone: _____

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant other

Care Team

Referring physician: _____ Primary care physician: _____

Pharmacy name: _____ Pharmacy address / phone: _____

Reason for Visit

Please briefly describe your current symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any? _____

Other practitioners you have seen for this problem: _____

Other rheumatology practitioners you have seen: _____

Previous treatment for this problem (include physical therapy, surgery, injections, and medications):

Drug Allergies

☐ None ☐ Yes If yes, medication and type of reaction: _____

Past Medical History

Check all that apply

☐ Anemia	☐ Heart attack	☐ Psoriatic arthritis
☐ Ankylosing spondylitis	☐ Heart disease / CHF	☐ Rheumatoid arthritis
☐ Anxiety	☐ High blood pressure	☐ Sjögren's syndrome
☐ Asthma	☐ High cholesterol	☐ Sleep apnea
☐ Blood clots	☐ HIV / STDs	☐ Stomach ulcers
☐ Celiac disease	☐ Kidney disease / stones	☐ Stroke
☐ Crohn's disease	☐ Liver disease	☐ Temporal arteritis
☐ Depression	☐ Lupus	☐ Thyroid disease
☐ Diverticulitis	☐ Migraine headaches	☐ Tuberculosis
☐ Emphysema / COPD	☐ Neuropathy	☐ Uveitis / iritis
☐ Epilepsy / seizures	☐ Osteoarthritis	☐ Cancer – type: _____
☐ Fibromyalgia	☐ Osteoporosis	☐ Diabetes – type: _____
☐ GERD	☐ Pneumonia	☐ Hepatitis – type: _____
☐ Glaucoma	☐ PMR (polymyalgia rheumatica)	
☐ Gout	☐ Psoriasis	

Other pertinent medical history: _____

Family History

List blood relatives (e.g., mother, brother) who have any of the following

Osteoarthritis		Rheumatoid arthritis	
Gout		Fibromyalgia	
Lupus		Ankylosing spondylitis	
Osteoporosis		Crohn's / ulcerative colitis	
Sjögren's syndrome		Psoriasis / psoriatic arthritis	
PMR / GCA / temporal arteritis		Other autoimmune disease	

Past Surgical History

Check all that apply and enter the year

Procedure	Year	Procedure	Year
☐ Knee replacement: R / L / Both		☐ Carpal tunnel surgery	
☐ Hip replacement: R / L / Both		☐ Tubal ligation	
☐ Shoulder surgery		☐ Hysterectomy	
☐ Arthroscopic surgery		☐ Colon surgery	
☐ Neck surgery		☐ Gallbladder surgery	
☐ Back surgery		☐ Weight-loss surgery	
☐ Foot surgery		☐ Vascular surgery	
☐ Hand surgery		☐ Cardiac surgery	

Other past surgeries (with year): _____

Current Providers

List the providers you currently see

Specialty	Provider name and location	Specialty	Provider name and location
Cardiology (heart)		Oncology (cancer)	
Dermatology (skin)		Optometry / Ophthalmology (eye)	
Gastroenterology (stomach)		Orthopedics	
Nephrology (kidney)		Podiatry (feet)	
Neurology (brain)		Pulmonology (lung)	
Neurosurgery (spine)		Urology (bladder)	
OB/GYN (women's health)		Other: _____	

Personal and Social History

Highest education level: ☐ High school ☐ Some college ☐ College graduate ☐ Advanced degree

Current occupation: _____

Currently working? ☐ Yes – hours/week: _____ ☐ No **If no:** ☐ Retired ☐ Disabled ☐ On sick leave

How much exercise do you get each week? _____

What kind of exercise? _____

Question	No	Yes	Details
Any previous fractures?	☐	☐	If yes, describe:
Any other serious injuries?	☐	☐	If yes, describe:
Do you smoke or use tobacco?	☐	☐	Type / amount per day:
Do you drink alcohol?	☐	☐	Type / amount per week:
Do you drink caffeinated beverages?	☐	☐	Type / amount per day:
Do you use drugs for recreational or non-medical reasons?	☐	☐	If yes, describe:

On average, how many hours do you sleep each night? _____

Do you get enough sleep? ☐ Yes ☐ No **Do you wake up feeling rested?** ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No **Do you use contraceptives?** ☐ Yes ☐ No Type: _____

Activities of Daily Living

Do you have stairs to climb at home? ☐ Yes – how many? _____ ☐ No

Number of people in household: _____ Relationship and age of each: _____

Who does most of the housework? _____ Shopping? _____ Yard work? _____

Most of the time, I function... (check one)

☐ 1 – Very poorly	☐ 2 – Poorly	☐ 3 – OK	☐ 4 – Well	☐ 5 – Very well
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Screening History

Date of last eye exam: _____ Date of last chest X-ray: _____

Date of last bone density test: _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date performed: _____

Review of Systems Check any you have ever experienced

GENERAL

- ☐ Weight gain – how much? _____
- ☐ Weight loss – how much? _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLES / JOINTS / BONES

- ☐ Morning stiffness
Lasting ____ min / ____ hr
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Joint swelling
- Joint(s) affected in the last 6 months:

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

NOSE

- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Frequent sinus infections

BLOOD

- ☐ Anemia
- ☐ Bleeding tendency

MOUTH

- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Pain in jaw while chewing

NECK

- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Sudden changes in heartbeat
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting / loss of consciousness
- ☐ Numbness or tingling in hands or feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC

- ☐ Depression
- ☐ Excessive worry
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting blood or “coffee grounds”
- ☐ Yellowing of skin (jaundice)
- ☐ Increased constipation
- ☐ Persistent diarrhea
- ☐ Blood in stool
- ☐ Black stools

KIDNEY / BLADDER

- ☐ Difficult urination
- ☐ Pain or burning with urination
- ☐ Blood in urine
- ☐ Cloudy or “smoky” urine
- ☐ Pus in urine
- ☐ Frequent urination
- ☐ Getting up at night to urinate

SKIN

- ☐ Bruising easily
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitivity
- ☐ Skin tightness
- ☐ Nodules / bumps
- ☐ Hair loss
- ☐ Color change in hands or feet in the cold (Raynaud's)

REPRODUCTIVE

- ☐ Genital rashes or ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble
- ☐ Vaginal dryness

WOMEN ONLY

Date of last menstrual period: _____
Have you reached menopause?
☐ No ☐ Yes – at age _____
Total number of pregnancies: _____
Total number of live births: _____

Current Medications List everything you take, including aspirin, vitamins, laxatives, calcium, and other supplements

Medication name	Dose (strength and pills per day)	How long taken?	Has it helped?		
			A lot	Some	Not at all
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Past Arthritis Medications

Please review this list and check any medications you have taken. As accurately as possible, note how long you took each one, how well it worked, and any reactions you had.

Medication	Length of time	Has it helped?			Reactions / comments
		A lot	Some	Not at all	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
NSAIDs (any)		☐	☐	☐	
Circle any taken: Aspirin • Celecoxib • Diclofenac • Etodolac • Ibuprofen • Indomethacin • Ketoprofen • Naproxen • Salsalate • Other: _____					
Pain Relievers					
Acetaminophen		☐	☐	☐	
Codeine		☐	☐	☐	
Gabapentin		☐	☐	☐	
Pregabalin		☐	☐	☐	
Tramadol		☐	☐	☐	
Disease-Modifying Antirheumatic Drugs (DMARDs) and Biologics					
Hydroxychloroquine		☐	☐	☐	
Methotrexate		☐	☐	☐	
Sulfasalazine		☐	☐	☐	
Leflunomide		☐	☐	☐	
Azathioprine		☐	☐	☐	
Mycophenolate (CellCept)		☐	☐	☐	
Adalimumab (Humira) / biosimilars		☐	☐	☐	
Etanercept (Enbrel) / biosimilars		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Cimzia		☐	☐	☐	
Cosentyx		☐	☐	☐	
Orencia		☐	☐	☐	
Otezla		☐	☐	☐	
Rinvoq		☐	☐	☐	
Taltz		☐	☐	☐	
Xeljanz		☐	☐	☐	
Other: _____		☐	☐	☐	

Past Medications (continued)

Medication	Length of time	Has it helped?			Reactions / comments
		A lot	Some	Not at all	
Osteoporosis Medications					
Alendronate		☐	☐	☐	
Calcitonin (injection or nasal)		☐	☐	☐	
Estrogen		☐	☐	☐	
Etidronate		☐	☐	☐	
Fluoride		☐	☐	☐	
Raloxifene		☐	☐	☐	
Risedronate		☐	☐	☐	
Other: _____		☐	☐	☐	
Other: _____		☐	☐	☐	
Gout Medications					
Allopurinol		☐	☐	☐	
Colchicine		☐	☐	☐	
Febuxostat		☐	☐	☐	
Krystexxa		☐	☐	☐	
Probenecid		☐	☐	☐	
Other Medications					
Cortisone / Prednisone		☐	☐	☐	
Hyaluronan		☐	☐	☐	
Tamoxifen		☐	☐	☐	
Tiludronate		☐	☐	☐	
Herbal or nutritional supplements		☐	☐	☐	

Please list supplements: _____

Clinical Trials

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, please list: _____



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