Rheumatology Center, Inc.
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NEW PATIENT FORM

Name: _____ Date of Birth: _____

Surgical History

Surgical Procedures/ Serious Injuries/ Illnesses	Year	Physician	Hospital

Medications

If you are a new patient with The Rheumatology Center, please list all medications and the dosages:

Drug Name	Dose	How Often?

Allergies

Please check all allergies:

- ❒ Medications: _____
- ❒ Foods: _____
- ❒ Tapes: _____
- ❒ Novocaine:_____
- ❒ Anesthetics: _____

What types of reactions have you experienced?

_____

_____

Family History

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: Brothers ____ Sisters ____ Alive? _____ If not, cause? _____

Number of children: Sons ____ Daughters ____ Alive? _____ If not, cause? _____

At any time have you or a blood relative had any of the following? (Check if "yes")

	Yourself	Relative	→	Relationship
Arthritis (type unknown)	❑	❑	→	
Osteoarthritis	❑	❑	→	
Rheumatoid arthritis	❑	❑	→	
Gout	❑	❑	→	
Lupus or "SLE"	❑	❑	→	
Ankylosing spondylitis	❑	❑	→	
Childhood arthritis	❑	❑	→	
Sjogren's syndrome	❑	❑	→	
Osteoporosis	❑	❑	→	
Psoriasis/psoriatic arthritis	❑	❑	→	
Diabetes mellitus	❑	❑	→	
High Blood Pressure	❑	❑	→	
Heart Disease	❑	❑	→	
Other:	❑	❑	→	

Social History

Occupation: _____

Marital Status: ____ Single ____ Married ____ Divorced ____Widowed

Do you smoke currently? ____ Yes ____ No How many packs per day? _____ For how long? _____

Have you smoke previously? ____ Yes ____ No If yes, how many packs/day? _____ When did you quit? _____

Do you use illicit drugs? ____ Yes ____ No

Do you drink alcoholic beverages? ____ Yes ____ No If yes, how often? _____

Have you ever had a blood transfusion? ____ Yes ____ No If yes, what year was the transfusion? _____

Do you exercise? ____ Yes ____ No If yes, what type of exercise? _____

How many times/weeks? _____

Have you?	**Yes**	**No**	**If yes, please specify:**
Have you been seen by a specialist (please indicate their name)?	❒	❒	_____ _____
Had an X-Ray, MRI, CT Scan, Ultrasound, or a Nerve Conduction Study?	❒	❒	_____ _____
Had any bloodwork performed with any other doctor?	❒	❒	_____ _____
Been hospitalized? If so, where?	❒	❒	_____ _____
FOR <u>INFUSION</u> PATIENTS ONLY: Been treated with any antibiotics or have a fever?	❒	❒	_____ _____
FOR <u>MEDICARE</u> PATIENTS ONLY: Had a visit with your PCP recently?	❒	❒	_____ _____