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?	❒	❒	_____ _____

REVIEW OF SYSTEM

*** CIRCLE IF ANY: *PLEASE CIRCLE ONLY WHAT YOU FEEL TODAY****

General/Constitutional

-Change in appetite -Chills -Fatigue - Fever - Headache

Ophthalmologic/ENT

- Blurred vision - Dry eye - Pain -Dry mouth -Mouth sores

Respiratory

- Chest pain - Cough - Hemoptysis

Cardiovascular

- Dyspnea on exertion - Palpitations - Shortness of breath

Gastrointestinal

- Abdominal pain - Constipation - Diarrhea

Hematology

- Weakness - Weight loss

Musculoskeletal

- Joint stiffness - Muscle aches - Painful joints - Swollen joints

Skin

- Nodule(s) - Rash -Color changes in fingers when exposed to cold

Neurologic

- Balance difficulty - Gait abnormality - Tingling/Numbness

Psychiatric

- Anxiety - Depressed mood - Difficulty sleeping - Loss of appetite

Have you had the flu shot? YES NO
If yes, when and where? _____

Have you had the Pneumonia shot? YES NO
If yes, when and where? _____

*****OFFICE USE ONLY*****

VITALS:

BP: _____

HR: _____

Wt:_____

EXAMEN DEL SISTEMA

CÍRCULE EN SU CASO: *POR FAVOR, CÍRCULE SOLO LO QUE SIENTE HOY*

General / Constitucional

-Cambios en el apetito -Resfriado -Fatiga -Fiebre -Dolor de cabeza

Oftalmológica/ENT

-Visión borrosa -Ojo seco - Dolor -Boca seca -Ulceras en la boca

Respiratorio

-Dolor de pecho -Tos -La hemoptisis

Cardiovascular

-La disnea de esfuerzo -Palpitaciones -Dificultad para respirar

Gastrointestinal

-Dolor abdominal -Estreñimiento -Diarrea.

Hematología

-Debilidad -Pérdida de peso

PARA USO DE OFICINA

VITALS:

BP: _____

HR: _____

Wt:_____

Musculoesqueléticas

-Rigidez en las articulaciones -Dolores musculares -Articulaciones dolorosas -Articulaciones inflamadas.

Piel

-Nódulo(s) -Erupción -Cambio de color de dedos cuando en el frio

Neurológica

-Dificultad Balance -Alteración de la marcha -Hormigueo / adormecimiento

Psiquiátrico

-Ansiedad -Estado de ánimo deprimido -Dificultad para dormir -Pérdida de apetito

Te haz hecho la vaccuna de neumonia? SI NO

Cuando y adonde?_____

Te haz Hecho la vaccuna de la gripe? SI NO

Cuando y adonde?_____