ARTHRITIS & RHEUMATOLOGY CARE, P.C.

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http://www.nyarthritis.com

Name: _____ **Date**: _____
Birthplace: _____ Date of Brith: _____

ALLERGIES: Are you allergic to any medication? ◯ Yes ◯ No
If yes, to what? ☐ Penicillin. If so, what happened? _____
☐ Sulfa. If so, what happened? _____
☐ Aspirin. If so, what happened? _____
☐ Others. If so, what happened? _____
Food allergies (i.e. peanut, egg, shellfish, etc.) ◯ Yes ◯ No
If yes, to what? _____

GENERAL:
Please describe your present symptoms (what brings you in today?)

_____
_____
_____

Were you referred for an abnormal blood test result? ◯ Yes ◯ No
If so, what was the concern (check all that apply):

☐ Positive ANA	☐ Elevated rheumatoid Factor	☐ ESR	☐ CRP

Do you have early morning joint stiffness? ◯ Yes ◯ No
Do you have pain? ◯ Yes ◯ No

Have you ever been seen by a rheumatologist? ◯ Yes ◯ No
If so, what was the diagnosis and treatment?

_____

ABOUT YOUR SYMPTOMS:
Do your symptoms: ◯ come and go ◯ steady all the time
When do you have your symptoms?

	Morning	Afternoon	Evening	Night
Most	◯	◯	◯	◯
Least	◯	◯	◯	◯

List your symptoms and dates when they began:

	Date		Date
Mult. miscarriages		Hearing loss	
Sinusitis		Asthma	
Hair loss (balding)		Rash/psoriasis	
Fetal death			

Select one: symptoms started: ◯ All of a sudden ◯ Gradually

This form has four pages – each needs to be filled out!

Did you have any of the following prior to the onset of your symptoms?

☐ Viral syndrome	☐ Stomach virus	☐ Stressful situation	☐ CRP
☐ Car accident	☐ Other injury	☐ Others:	

Previous treatments for this problem:

☐ Physical Therapy	☐ Surgery	☐ Medication	☐ Injection

Did you ever take corticosteroids? ○ Yes ○ No
Did you ever break a bone? ○ Yes ○ No

PAIN:

If so, please indicate the **type** of pain and **location**:

	Side		Aching	Burning	Stabbing	Crampy	Electric shock	Pins & needles	Pulling
	R	L							
Fingers	☐	☐	○	○	○	○	○	○	○
Wrist	☐	☐	○	○	○	○	○	○	○
Elbow	☐	☐	○	○	○	○	○	○	○
Shoulder	☐	☐	○	○	○	○	○	○	○
Hip	☐	☐	○	○	○	○	○	○	○
Knee	☐	☐	○	○	○	○	○	○	○
Ankle	☐	☐	○	○	○	○	○	○	○
Toes	☐	☐	○	○	○	○	○	○	○
Neck			○	○	○	○	○	○	○
Mid back			○	○	○	○	○	○	○
Low back			○	○	○	○	○	○	○
Arm			○	○	○	○	○	○	○
Muscles			○	○	○	○	○	○	○
Leg muscles			○	○	○	○	○	○	○

What affects your pain?

	Rest	Activity	Medication	Exercises	Ice	Heat	Others
Better	☐	☐	☐	☐	☐	☐	☐
Worse	☐	☐	☐	☐	☐	☐	☐

PERTINENT SYMPTOMS:

Please indicate if you experienced any of the below:

☐ Blood clot, deep vein thrombosis or pulmonary embolism	☐ Fingers changing color in the cold or due to stress (white to blue to red)?
☐ Dry mouth	☐ Glaucoma
☐ Vaginal dryness	☐ Constipation
☐ Itchy red skin on sun exposure	☐ Sores in nose or mouth
☐ Muscle pain	☐ Numbness or tingling
☐ Swollen lymph nodes or swollen glands	☐ Dry eyes
☐ Chest pain	☐ Diarrhea
☐ Shortness of breath	☐ Stroke

☐	Family history of blood clot or stroke at a young age	☐	Abdominal pain, liver problems, or Hepatitis B/C
☐	Kidney Failure	☐	Kidney Stones
☐	Protein in the urine	☐	Diabetes
☐	Thyroid condition	☐	Cataract
☐	Miscarriages	☐	Blood clot in artery or vein or pulmonary embolism
☐	Pain or burning on urination	☐	Urinary retention

SLEEP:

Do your symptoms disturb your sleep? ◯ Yes ◯ No
Do you get enough sleep at night? ◯ Yes ◯ No
Do you wake up feeling rested? ◯ Yes ◯ No
How many hours do you sleep per night? _____ hours
Do you work the night shift or alternating day/night shifts? ◯ Yes ◯ No

TESTS:

Did you have any of the following done? If so, when?

	Date		Date
Chest X-Ray		Colonoscopy	
Mammogram		Bone density test	
Pelvic exam (women only)		Skin biopsy	
PSA (men only)		Rectal exam	
Colonoscopy		Kidney biopsy	

VACCINES:

☐ Pneumonia 13 ☐ 23 valent ☐ Flu ☐ Pneumonia ☐ Shingles

HOSPITALIZATIONS:

Reason	Year

SURGERIES:

Type	Reason	Year

SOCIAL HISTORY:

Do you **smoke**? ◯ Never
◯ Yes: Packs/Day: ___ # / Years: ___
◯ Past: Year quit? _____
Do you drink **alcohol**? ◯ No ◯ Yes: # Drink / week: ___
Do you **exercise** regularly? ◯ No ◯ Yes: Amount / week: ___
Did you ever use **drugs** for reasons that are not medical? ◯ No ◯ Yes:

If yes, please list: _____

MARITAL STATUS:

◯ Never Married	◯ Married	◯ Divorced	◯ Separated	◯ Widowed

Spouse/Significant Other:

◯ Alive/Age: ____ ◯ Deceased/Age ____ ☐ Major Illness: _____

EDUCATION:

Grade School ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 College ☐ 1 ☐ 2 ☐ 3 ☐ 4

Graduate School: _____

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

#of Siblings _____ # living _____ # deceased _____

# of Children _____ # living # deceased List ages

Health of Children _____

Do you or any blood relative have or had:

	Condition	Who had it?		Condition	Who had it?
☐	Rheumatoid Arthritis		☐	Psoriasis	
☐	Lupus		☐	Thyroid Disease	
☐	Crohn's disease		☐	Ulcerative Colitis	
☐	Asthma		☐	Tuberculosis	
☐	Gout				
☐	Blood clot in an artery of vein or stroke at young age				

PRESENT MEDICATIONS:

Please list any medications you are taking, INCLUDING such items as aspirin, vitamins, laxatives, calcium, herbal supplements, etc.

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

Submit Reset