

# Rheumatology New Patient History Form

Please print form, fill it out and bring it to your scheduled appointment

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Name:(First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last:) \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_ Sex: Male / Female

Marital Status:  Never Married  Married  Divorced  Separated  Widowed

Spouse:  Alive/Age \_\_\_\_  Deceased/Age \_\_\_\_ Major Illnesses \_\_\_\_\_

Education: (Circle highest level attended):

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

Occupation: \_\_\_\_\_ # of hours worked per week \_\_\_\_\_

Referred here by:  Self  Family  Friend  Doctor  Other Health Care Professional

Name of person making referral: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Do you have an orthopedic surgeon? Y / N If yes, name: \_\_\_\_\_

Describe briefly your present symptoms: \_\_\_\_\_

Date symptoms began: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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

Names of practitioners you have seen for this problem: \_\_\_\_\_

Date of last:

Mammogram: \_\_\_\_/\_\_\_\_/\_\_\_\_ Eye Exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

Tuberculosis test: \_\_\_\_/\_\_\_\_/\_\_\_\_ Bone Densitometry: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Questions or concerns? Please feel free to call us at the Rockwood Clinic  
Rheumatology Department: (509) 838-2531 ext.4380 or 1-800-772-4048 ext.4380.**

**The Rockwood Clinic Rheumatology Department is located on 3W  
in the Main Rockwood Clinic at 400. East 5th Avenue.**



As you review the following list, please check any problems which have significantly affected you.

**Constitutional**

- Recent weight loss  
amount \_\_\_\_\_
- Recent weight gain  
amount \_\_\_\_\_
- Fatigue
- Weakness
- Fever

**Eyes**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

**Ears, Nose, Mouth, Throat**

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

**Cardiovascular**

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

**Respiratory**

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing blood
- Wheezing (asthma)

**Gastrointestinal**

- Nausea
- Vomiting blood or coffee  
ground material
- Stomach pain relieved  
by food or milk
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

**Musculoskeletal**

- Morning stiffness  
Lasting how long?  
\_\_\_\_\_ minutes \_\_\_\_\_ hours

- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling
- List joints affected in the last 6 mo.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Genitourinary**

- Difficult urination
- Pain or burning in urination
- Blood in urine
- Cloudy urine
- Pus in urine
- Discharge form penis / vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

*For women only:*

- Age when period began \_\_\_\_\_
- Periods regular: Y / N
- How many days apart? \_\_\_\_\_
- Date of last period: \_\_\_\_\_
- Date of last pap: \_\_\_\_\_
- Bleeding after menopause: Y / N
- # of pregnancies: \_\_\_\_\_
- # of miscarriages: \_\_\_\_\_

**Integumentary (skin and/or breast)**

- Easy burning
- Redness
- Rash/ulcers
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules / bumps
- Hair loss
- Color change in hands & feet when cold

**Neurological System**

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain in hands or feet
- Memory loss
- Night sweats

**Psychiatric**

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

**Endocrine**

- Excessive thirst

**Hematologic / Lymphatic**

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion (when: \_\_\_\_\_)

**Allergic/Immunologic**

- Frequent sneezing
- Increased susceptibility to infection

**Rheumatologic History**

At any time, have you or a blood relative had any of the following (check if "yes.")

Yourself		Relative Name / Relationship	Yourself		Relative Name / Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	

**Social History**

Do you drink caffeinated beverages?  
 Cups/glasses per day \_\_\_\_\_  
 Do you smoke? Y / N How long? \_\_\_\_\_  
 Do you drink alcohol? Y / N How many per week \_\_\_\_\_  
 Has anyone ever told you cut down? Y / N  
 Do you use recreational drugs? Y / N  
 If yes, please list: \_\_\_\_\_  
 Do you exercise regularly? Y / N  
 Type \_\_\_\_\_  
 Amount per week \_\_\_\_\_  
 How many hours of sleep do you get at night? \_\_\_\_\_  
 Do you get enough sleep at night? Y / N  
 Do you wake up feeling rested? Y / N

**Past Medical History**

Do you now or have you ever had:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Goiter	<input type="checkbox"/> HIV / Aids
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Nervous Breakdown	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Colitis
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Leukemia	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Pneumonia

**Natural or alternative therapies you have tried:**  
 (chiropracty, magnets, massage, over-the-counter preparations, etc.) \_\_\_\_\_

Other significant illnesses (please list):  
 \_\_\_\_\_

**Previous Operations**

	Type:	Year	Reason:
1			
2			
3			
4			
5			
6			

Any previous fractures? Y / N Describe: \_\_\_\_\_  
 Any other serious injuries Y / N? Describe: \_\_\_\_\_

**Family History**

	If living		If deceased	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_  
 Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ Ages \_\_\_\_\_  
 Health of children: \_\_\_\_\_

Do you know of any blood relative who has ever had:

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Goiter       |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> Epilepsy          |                                       |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Asthma            |                                       |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psoriasis         |                                       |

Drug allergies: Y / N To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS:**

(List any you are taking. Include aspirin, vitamins, laxatives calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day.	How long have you taken this medication?	Helped A lot	Helped Some	Helped Not at all
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PAST MEDICATIONS:** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list the reactions you may have had. Record your comments below.

Drug names/Dosage	Length of time	Helped A lot	Helped Some	Helped Not at all	Reactions
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Circle any you have taken in the past:                      Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib)                      Clinoril (sulindac) Daypro (oxaprozin) Disalcid (diflunisal) Feldene (piroxicam) Indocin (indomethacin)                      Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen)                      Oruviel (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)</p>					
<b>Pain relievers</b>					
Acetaminophen (Tylenol)					
Codeine (Vicodin, Tylenol 3)					
Propoxyphene (Darvocet)					
Other:					
Other:					
<b>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychoquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine (Sandimmune)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Calumn		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Drug names/Dosage	Length of time	Helped A lot	Helped Some	Helped Not at all	Reactions
<b>Osteoporosis Medications</b>					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etdronate ( Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluroide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injections or nasal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gout Medications</b>					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Others</b>					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal/Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list suppliments:					

Have you participated in any clinical trials for new medications? Y / N

If yes, list \_\_\_\_\_

\_\_\_\_\_



