THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

UT RHEUMATOLOGY
A Department of the University of Tennessee Medical Center
1932 Alcoa Hwy
Medical Building C, Suite 550
Knoxville, TN 37920
865-305-6543 (Phone) | 865-305-2694 (Fax)
UTRheumatology@utmck.edu

NEW PATIENT HISTORY FORM

Date: _____ **Birthplace**: _____

Name: _____
Last First MI Maiden

Birthdate: _____ **Age**: _____ **Sex**: Female ☐ Male ☐

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address:_____

_____

Marital Status (Circle One): Married Single Divorced Separated Widowed

Spouse/Significant Other: Alive/Age_____ Deceased/Age_____ Major Illness_____

Education: Check highest level attended.
Grade School: __7 __8 __9 __10 __11 __12

College: __1 __2 __3 __4 Graduate School: _____
Occupation: _____ Average No. Hours worked/per week_____

Retired (Date Retired):_____

Referred here by (circle one): Self Family Friend Doctor Other Health Professional
Name of person making referral: _____
Name of physician providing your primary medical care: _____
Have you seen a rheumatologist? No___ Yes ___ If yes, when?: _____
Rheumatologist name:_____

Describe briefly your present symptoms: _____

_____

_____

Date Symptoms began (approximate):_____

Diagnosis: _____

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

_____

_____

Do you have an orthopedic surgeon? No___ Yes ___ If yes, name: _____

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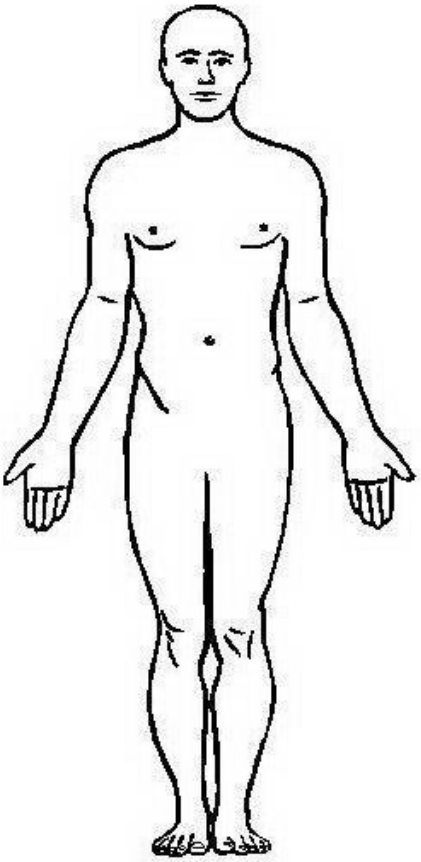
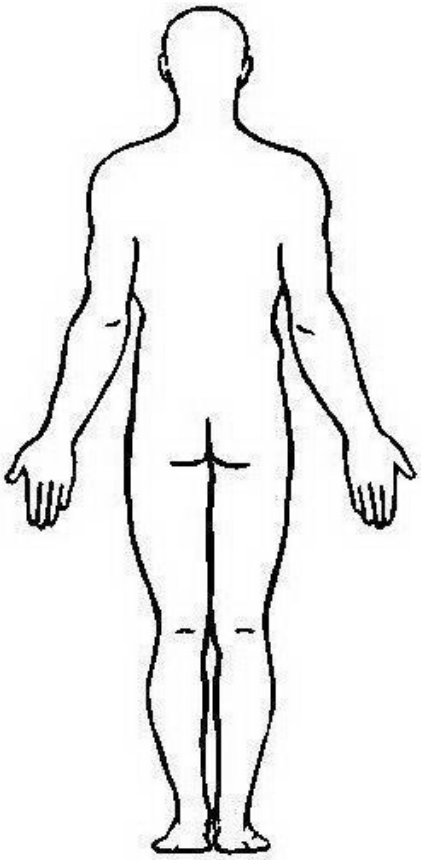
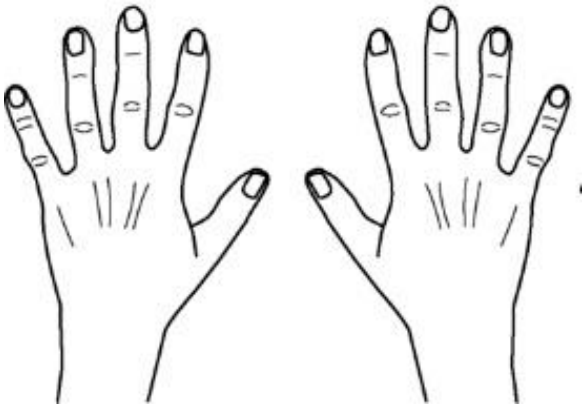
Please list the names of any practitioners you have seen for this problem:_____

_____

Please place an "X" on all the locations of your pain over the past week by marking on the appropriate areas







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NEW PATIENT HISTORY FORM

Systems Review

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

Constitutional	Gastrointestinal	Integumentary (skin, and/or breast)
☐ Recent weight gain	☐ Nausea	☐ Easy bruising
Amount_____	☐ Vomiting of blood or coffee ground material	☐ Redness
☐ Recent weight loss		☐ Rash
Amount_____	☐ Stomach pain relieved by food or milk	☐ Hives
☐ Fatigue		☐ Sun sensitive (sun allergy)
☐ Weakness	☐ Jaundice	☐ Tightness
☐ Fever	☐ Increasing constipation	☐ Nodules/bumps
Eyes	☐ Persistent diarrhea	☐ Hair loss
☐ Pain	☐ Blood in stools	☐ Color changes of hands or feet in the cold
☐ Redness	☐ Black stools	
☐ Loss of vision	☐ Heartburn	**Neurologic System**
☐ Double or blurred vision	**Genitourinary**	☐ Headaches
☐ Dryness	☐ Difficult urination	☐ Dizziness
☐ Feels like something in eye	☐ Pain or burning on urination	☐ Fainting
☐ Itching eyes	☐ Blood in urine	☐ Muscle spasm
Ears-Nose-Mouth-Throat	☐ Cloudy, "smoky" urine	☐ Loss of consciousness
☐ Ringing in ears	☐ Pus in urine	☐ Sensitivity/pain of hands or feet
☐ Loss of hearing	☐ Getting up at night to pass urine	☐ Memory loss
☐ Nose bleeds	☐ Discharge from vagina/penis	☐ Night sweats
☐ Loss of smell	☐ Genital Rash/ulcers	**Psychiatric**
☐ Dryness of nose	☐ Sexual difficulties	☐ Excessive worries
☐ Runny nose	*For Women Only*	☐ Anxiety
☐ Sore tongue	Age when periods began:	☐ Easily losing temper
☐ Bleeding gums	Periods regular? __Yes __ No	☐ Depression
☐ Sores in mouth	How many days apart?	☐ Agitation
☐ Loss of taste	Date of last period:	☐ Difficulty falling asleep
☐ Dryness of mouth	Date of last PAP:	☐ Difficulty staying asleep
☐ Frequent sore throats	Bleeding after menopause: __Yes __No	**Endocrine**
☐ Hoarseness	Number of pregnancies?	☐ Excessive thirst
☐ Difficulty in swallowing	Number of miscarriages?	**Hematological/Lymphatic**
☐ Excess dental cavities	*For Men Only*	☐ Swollen or tender glands
Cardiovascular	☐ Prostate trouble	☐ Anemia
☐ Pain in chest	**Musculoskeletal**	☐ Bleeding tendency
☐ Irregular heart beat	☐ Morning stiffness	☐ Clotting tendency
☐ Sudden changes in heart beat	Lasting how long?	☐ Transfusion, when_____
☐ High blood pressure	_____ Minutes _____ Hours	**Allergic/Immunologic**
☐ Heart murmurs	☐ Joint Pain	☐ Frequent sneezing
Respiratory	☐ Muscle weakness	☐ Increased susceptibility to infection
☐ Shortness of breath	☐ Muscle tenderness	
☐ Difficulty breathing at night	☐ Joint swelling	☐ Frequent sinus congestion
☐ Swollen legs or feet	List joints affected in the last 6 months:	
☐ Cough		
☐ Coughing of blood		
☐ Wheezing (asthma)		

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NEW PATIENT HISTORY FORM

Past Medical History

Do **you** now or have you ever had: (**only check those that apply for you**)

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous Breakdown	☐ Stomach ulcers	☐ Rheumatic Fever
☐ Bad headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ High Blood Pressure
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis
☐ Hepatitis	☐ Osteoarthritis	☐ Childhood arthritis
☐ Rheumatoid Arthritis	☐ Gout	☐ Lupus or SLE
☐ Psoriatic Arthritis	☐ Ankylosing Spondylitis	☐ Osteoporosis

Arthritis conditions:

Other significant illness (please list):

_____

Non-pharmacologic, Natural, or Alternative Therapies:

☐ chiropractic	☐ hypnosis	☐ Other:_____
☐ acupuncture	☐ massage	_____
☐ physical Therapy	☐ occupational Therapy	_____

Past Surgical History (Operations)

Type	Year	Reason

Any previous **fractures**? ___ No ___ Yes
Describe:

Any other **serious injuries**? ___ No ___ Yes
Describe:

Health Maintenance

Please state the date of your last:

Mammogram:	Eye exam:
Chest x-ray:	Tuberculosis test:
Bone Densitometry (DEXA):	Flu Vaccine:
Pneumococcal Vaccine:	Tetanus Vaccine:
Prevnar Vaccine:	Hepatitis B Vaccine:
Shingles Vaccine:	

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NEW PATIENT HISTORY FORM

Rheumatologic Family History

At any time have your blood relatives had any of the following?

(**Only include Mother, Father, Sister, Brother, and/or Grandparents**)

	Relative (relationship)		**Relative** (relationship)
Arthritis (unknown type)		Lupus	
Osteoarthritis		Rheumatoid arthritis	
Gout		Ankylosing Spondylitis	
Childhood arthritis		Osteoporosis	

Family History

	If Living		If Deceased	
	Age	**Health**	**Age at death**	**Cause**
Father				
Mother				

Brothers/Sisters:	**Age**	**Sex**		**Age at death**	**Cause**

Sons/Daughters:	**Age**			

Do you know of any blood relative who has had:

(**Only include Mother, Father, Sister, Brother, and/or Grandparents**)

☐ Cancer	☐ High blood pressure	☐ Asthma
☐ Leukemia	☐ Bleeding tendency	☐ Psoriasis
☐ Stroke	☐ Alcoholism	☐ Tuberculosis
☐ Colitis	☐ Rheumatic Fever	☐ Diabetes
☐ Heart disease	☐ Epilepsy	☐ Goiter
☐ Arrhythmia	☐ Clotting disorder	☐ Hypothyroidism

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NEW PATIENT HISTORY FORM

Social History

Do you drink **caffeinated beverages**? ___Yes ___No

If yes, cups/glasses per day? _____

Do you **smoke**? ___Yes ___ No ___

Circle all that apply: Cigarettes Cigars Oral Pipe Electronic Nicotine Device Marijuana

Past: How long ago? _____ How much? _____

Have you had attempts to quit? ___Yes ___ No If yes, how long?

Do you drink **alcohol**? ___Yes ___ No

Circle all that apply: Beer Wine Liquor Other_____

Number per week: _____

Has anyone ever told you to cut down on your drinking? ___Yes ___ No

Do you use **drugs** for reasons that are not medical? ___ Yes ___ No

If yes; List:

Exercise: Do you exercise regularly? ___ Yes ___ No Amount per week: _____

Type of exercise:

Sleep: How many hours of sleep do you get at night? _____hours

Do you get enough sleep at night? ___ Yes ___ No

Hobbies/recreation (optional): _____

Anything you would like to be able to do? _____

Diet (optional): Any restrictions? _____

How would you describe your diet? _____

Allergies

(Please list any and all allergies below)

_____

_____

_____

_____

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NEW PATIENT HISTORY FORM

Present Medications

(List any medications you are taking, including 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	Please check: Helped? A lot	Some	Not at all

Past Medications

Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

Please review this list of NSAIDS below and circle the ones you have taken in the past:

Ansaid (flurbiprofen)	Oruvail (ketoprofen)	Tolectin (tolmetin)
Arthrotec (diclofenac+misoprostil)	Lodine (etodolac)	Trilisate (choline magnesium tricalicylate)
Aspirin	Meclomen (meclofenamate)	
Celebrex (celecoxib)	Mobic (meloxicam)	Voltaren (diclofenac)
Daypro (oxaprozin)	Motrin, Advil (ibuprofen)	Pensaid (mefanamic acid)
Disalcid (salsalate)	Nalfon (fenoprofen)	Dolobid (diflunisal)
Feldene (piroxicam)	Naprosyn, Alleve (naproxen)	Bextra (valdecoxib)
Indocin (indomethacin)	Relefen (nabumetone)	Vioxx (rofecoxib)

Corticosteroids/prednisone/Medrol: drug name:_____ length of time: _____
Helped? ___A Lot ___Some ___Not at all
Reactions?

PHARMACY

Name: _____ Phone #: _____

Address: _____

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NEW PATIENT HISTORY FORM

Activities of Daily Living

Home Conditions:

Do you have stairs to climb? No___ Yes ___ If yes, how many? _____

How many people in household? _____

Relationship	Age

Who does the most of the **housework**? _____ **shopping**? _____ **yard work**? _____

On the scale below, check the box which best describes your situation: *Most of the time, I function….*

☐	☐	☐	☐	☐
Very poorly	Poorly	Ok	Well	Very well
1	2	3	4	5

Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Getting up from chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Bathing?			
Eating?			
Working?			
Getting along with family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			

Do you use a: ☐ cane ☐ crutches ☐ walker ☐ wheelchair

What is the hardest thing for you to do?

Are you receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

Do you have medically related lawsuit pending? ☐ Yes ☐ No