NEW PATIENT HEALTH HISTORY

Patient Name	Date of Birth	MRN	FIN (Encounter Number)

The information you provide today is very important regarding your healthcare.
Please answer the following questions carefully and thoroughly to the best of your ability.

Visit Information

Reason for today's visit:
Name of referring provider:
Please list all known **MEDICATION** allergies and associated reaction:

Please list all prescription and 'over the counter' medications you are currently taking:

Drug Name	Dose (how much)	Route (how it's taken)	Frequency (how often)	Indication (why)
Example: Aspirin	650 mg	By mouth (PO)	4 times a day	For Pain

Pharmacy Name:	Phone:

Place a check in the appropriate box for all the locations of your pain over the past week.

- ☐ Left Finger
- ☐ Left Wrist
- ☐ Left Elbow
- ☐ Left Shoulder
- ☐ Left Hip
- ☐ Left Knee
- ☐ Left Ankle
- ☐ Left Toes
- ☐ Right Fingers
- ☐ Right Wrist
- ☐ Right Elbow
- ☐ Right Shoulder
- ☐ Right Hip
- ☐ Right Knee
- ☐ Right Ankle
- ☐ Right Toes
- ☐ Back
- ☐ Neck
- ☐ Other: ___________________

Past Medical History

Have you been seen by a Rheumatologist in the past? ☐ Yes ☐ No When:
Name of Rheumatologist:
Other Physicians you are currently seeing:

ADULT PATIENT HEALTH HISTORY

Patient Name ____________________ Date of Birth __________ MRN __________ FIN (Encounter Number) __________

Do you have or have you ever had any of the following conditions?

- ☐ Cancer
- ☐ Diverticulitis
- ☐ Bad headaches
- ☐ Kidney disease
- ☐ Anemia
- ☐ Emphysema
- ☐ Hepatitis
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Heart problems
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ Pneumonia
- ☐ HIV / AIDS
- ☐ Glaucoma
- ☐ Previous Fracture
- ☐ Serious Injuries
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Ankylosing Spondylitis
- ☐ Asthma
- ☐ Stroke
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Colitis
- ☐ Psoriasis
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Childhood arthritis
- ☐ Lupus or SLE
- ☐ Osteoporosis
- ☐ Other ____________________

Past Surgeries

Please list any surgeries with associated dates:

____

____

Review of Systems:

Check all problems that have significantly affected you.

Ears / Nose / Mouth / Throat	Constitutional	Cardiovascular
☐ Ringing in ears	☐ Recent Weight Gain Amount:	☐ Pain in chest
☐ Loss of hearing	☐ Recent Weight Loss Amount:	☐ Irregular heartbeat
☐ Nose bleeds	☐ Fatigue	☐ High blood pressure
☐ Loss of smell	☐ Weakness	☐ Heart murmurs
☐ Dryness of nose	☐ Fever	☐ Sudden changes in heartbeat
☐ Runny nose		
☐ Sore tongue	**Eyes**	**Respiratory**
☐ Bleeding gums	☐ Pain	☐ Shortness of breath
☐ Sores in mouth	☐ Redness	☐ Difficulty breathing at night
☐ Loss of taste	☐ Loss of Vision	☐ Swollen legs or feet
☐ Dryness of mouth	☐ Double or blurred vision	☐ Cough
☐ Frequent sore throats	☐ Dryness	☐ Coughing up blood
☐ Hoarseness	☐ Feels like something in eye	☐ Wheezing (asthma)
☐ Difficulty in swallowing	☐ Itchy eyes	
☐ Excess dental cavities		

ADULT PATIENT HEALTH HISTORY

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Review of Systems Continued:

Psychiatric	Gastrointestinal	Genitourinary
☐ Excessive worries	☐ Nausea	☐ Difficult urination
☐ Anxiety	☐ Jaundice	☐ Pain or burning on urination
☐ Easily losing temper	☐ Increasing constipation	☐ Blood in urine
☐ Depression	☐ Persistent diarrhea	☐ Cloudy, “smoky” urine
☐ Agitation	☐ Blood in stools	☐ Pus in urine
☐ Difficulty falling asleep	☐ Black stools	☐ Frequent urination at night
☐ Difficulty staying asleep	☐ Heartburn	☐ Discharge from genital area
	☐ Vomiting blood or coffee ground material	☐ Genital Rash/ulcers
	☐ Stomach pain relieved by food or milk	☐ Sexual difficulties
Allergic/Immunologic	**Integumentary (skin, and/or breast)**	**Hematological/Lymphatic**
☐ Frequent sneezing	☐ Easy bruising	☐ Swollen or tender glands
☐ Increased susceptibility to infection	☐ Redness	☐ Anemia
☐ Frequent sinus congestion	☐ Rash	☐ Bleeding tendency
	☐ Hives	☐ Clotting tendency
Musculoskeletal	☐ Sun sensitive (sun allergy)	☐ Transfusion When?
☐ Joint pain	☐ Tightness	
☐ Muscle weakness	☐ Nodules/bumps	**Men Only**
☐ Muscle tenderness	☐ Hair loss	☐ Prostate trouble
☐ Joint swelling	☐ Color changes of hands / feet in the cold	
☐ Morning Stiffness How long:		**Women Only**
		Number of pregnancies
		Number of miscarriages

Social History

Religious or spiritual considerations:

Smoking

Do you smoke? ☐ Yes ☐ No	How often do you smoke?
Are you interested in stopping? ☐ Yes ☐ No	Have you ever smoked? ☐ Yes ☐ No

Alcohol

Do you drink alcohol? ☐ Yes ☐ No	How many drinks per week?

Drugs

Do you currently use prescription or street drugs for non-medicinal purposes? ☐ Yes ☐ No

Have you ever used prescription or street drugs for non-medicinal purposes? ☐ Yes ☐ No

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Wellness Practices

Do you exercise? ☐ Yes ☐ No	How many times per week?

Family History

Father

Does / did your father have any of the following illnesses or health conditions (check all that apply)?
☐ Arthritis (unknown type) ☐ Osteoarthritis ☐ Gout ☐ Childhood Arthritis ☐ Lupus ☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Other

Mother

Does/did your mother have any of the following illnesses or health conditions (check all that apply)?
☐ Arthritis (unknown type) ☐ Osteoarthritis ☐ Gout ☐ Childhood Arthritis ☐ Lupus ☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Other

Siblings

Do any of your siblings have any of the following illnesses or health conditions (check all that apply)?
☐ Arthritis (unknown type) ☐ Osteoarthritis ☐ Gout ☐ Childhood Arthritis ☐ Lupus ☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Other

Children

Do any of your children have any of the following illnesses or health conditions (check all that apply)?
☐ Arthritis (unknown type) ☐ Osteoarthritis ☐ Gout ☐ Childhood Arthritis ☐ Lupus ☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Other

Disabilities

Are you receiving disability benefits? ☐ Yes ☐ No