FALLS MEDICAL SPECIALISTS: RHEUMATOLOGY NEW PATIENT MEDICAL HISTORY FORM

Name: ____

Date of Birth: ___________________________________

Referred by (circle): Self PCP Other Specialist ______________________

Briefly what is bringing you in today: ____

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CURRENT MEDICATIONS (include over the counter medications such as ibuprofen, Tylenol, vitamins, supplements)

Name of Medication	Dose strength & number of pills per day
1.	
2.	
3.	
4.	
5.	
6	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Medication allergies: ____

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MEDICAL HISTORY: *Check if you have been diagnosed with any of the following conditions:*

☐ Allergies	☐ Depression	☐ Headache/ Migraines	☐ Osteoporosis
☐ Anemia	☐ Diabetes type 1 or 2	☐ Heart Disease	☐ Pneumonia
☐ Angina	☐ Elevated Lipids	☐ Hyperlipidemia	☐ Psoriasis
☐ Anxiety	☐ Emphysema	☐ Hypertension	☐ Psychiatric Disorders
☐ Arthritis	☐ Epilepsy	☐ Irritable Bowel	☐ Rheumatic Fever
☐ Asthma	☐ Gallbladder Disease	☐ Leukemia	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ GERD	☐ Liver Disease	☐ Seizure Disorder
☐ Blood Clots	☐ Goiter	☐ Lupus or 'SLE'	☐ Stroke
☐ COPD	☐ Gout	☐ Myocardial Infarction	☐ Stomach Ulcers
☐ Crohn's Disease	☐ HIV/AIDS	☐ Osteoarthritis	☐ Thyroid Disorder
☐ Colitis			☐ Tuberculosis (TB)

Please list additional medical history: ____

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SURGICAL HISTORY: ____

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FAMILY HISTORY: Include any family history of autoimmunity (ex. RA, lupus, Sjogrens, scleroderma, psoriasis, inflammatory bowel disease, ankylosing spondylitis, multiple sclerosis, celiac, Hashimoto's/Graves)

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SOCIAL HISTORY:
Occupation: ____

Smoking status: Never smoker Former smoker Current smoker cigs/day____

Alcohol use (drinks per week): ____

Relationship status: Single Married Divorced Widowed

REVIEW OF SYSTEMS: Please check any symptoms that you are currently experiencing

Constitutional			**Throat & Mouth**			**Genitourinary**		
No	**Yes**		**No**	**Yes**		**No**	**Yes**	
		Chills/Rigors			Change in taste			Change in Bladder
		Fatigue			Cold Sores			Change in urine color, if yes what color____
		Fever			Difficulty swallowing			Cloudy, “smoky” urine
		Night sweats			Hoarseness			Painful Urination
		Weight gain			Mouth sores			Difficulty with Urination
		Weight loss			Post nasal drainage			Blood in Urine
Eyes:					Sore tongue			Waking up at Night to Pass Urine
		Dry Eyes	**Respiratory:**			**Gender Specific:**		
		Double/Blurred Vision			Cough			Vaginal Dryness
		Feels like something is eye			Shortness of Breath			Genital Lesions
		Redness (eyes)			Spitting up Blood	**Integumentary:**		
		Itchy Eyes			Wheezing			Hair loss
		Eye Pain	**Gastrointestinal:**					Persistent Rash
		Vision Loss			Abdominal pain	**Neurological/Psychiatric**		
Ears:					Blood in stool			Headache
		Hearing Loss			Change in bowel habits			Numbness/Tingling (Paresthesias)
		Ringing in ears			Constipation	**Cardiovascular**		
Nose & Sinus:					Diarrhea			Chest pain
		Loss of Smell			Heartburn			Irregular heart beat/palpitations
		Nosebleeds			Jaundice			Shortness of Breath at Night
		Nose Sores			Nausea/ Vomiting			Swelling in Legs or Feet
Musculoskeletal								
		Muscle Pain			Muscle Weakness			
		Morning stiffness, if yes lasting how long ___________minutes/hours.						
		Bone/Joint Symptoms: list joints affected in the last six months________________________________						