NORTHSIDE

RHEUMATOLOGY &
PHYSICAL MEDICINE

English - Spanish

Patient Information

Patient Name: _____ Date of Birth: _____

Allergies & Reactions to Medications: _____

_____

Please list all current medications: _____

_____

_____

Pharmacy Name: _____ Pharmacy Phone: _____

Family History

Has anyone in your family (blood relatives) had any of the following? (Please check all boxes that apply.)

	Father	Mother	Siblings	Children	Grandparents
Arthritis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Uveitis	☐	☐	☐	☐	☐
Iritis	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Raynaud's	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐

_____

_____

Social History:

Marital Status: Single Married Divorced Widowed

Occupation: _____

Hobbies: _____

Please circle and fill in blanks if applicable

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Yes, if yes please answer the following

Type of Tobacco: Cigarettes Snuff Chewing Tobacco Currently _____ packs/day
Previously, but quit (when) _____ packs/day.

PATIENT INTAKE FOR RHEUMATOLOGY

Medical History:

Have you ever had or been diagnosed to have: *(check box by all that apply)*

OA-Osteoarthritis		Fibromyalgia		Osteoporosis		Cataracts		Heart Problems		Cancer (type)	
RA-Rheumatoid Arthritis		Gout		Psoriasis		Glaucoma		Stroke			
PSA - Psoriatic Arthritis		Scleroderma		Colitis		High Blood Pressure		Anemia			
Ankylosing Spondylitis		Sjogren's		Uveitis		Tuberculosis		Diabetes			
Lupus "SLE"		Raynaud's		Iritis		Kidney Disease		Asthma			

Rheumatology Specific Review of Systems:

Please indicate if you have had any of the following symptoms in the last 3 months by circling the Yes or No beside each item.

- Drenching Night sweats: YES NO
- Recurrent fevers: YES NO
- Dry eyes: YES NO
- Frequent dental cavities: YES NO
- Oral ulcers: YES NO
- Nasal Polyps: YES NO
- Frequent nose bleeds with large clots: YES NO
- Photosensitive rash: YES NO
- Pain in the jaw muscles immediately after starting to chew your food: YES NO
- Morning stiffness in the joints: YES NO
  If yes for how many minutes? _____
- Pitting in the fingernails: YES NO
- Chronic abdominal pain: YES NO
- Blood in the stool: YES NO
- If female, history of miscarriages: YES NO
- Unexplained weight loss: YES NO
- Eyes becoming painful, red, sensitive to light and difficult to see out of: YES NO
- Dry mouth: YES NO
- Difficulty swallowing your food: YES NO
- Genital ulcers: YES NO
- Fingers changing colors when they are cold: YES NO
- Facial Rash: YES NO
- New headaches: YES NO
- Joint pain: YES NO
- Joint swelling: YES NO
- Muscle weakness: YES NO
- Fingers or toes that are swollen and resemble sausages: YES NO
- Back pain that improves with exercise: YES NO
- Blood in the urine: No: YES NO
- History of Psoriasis, Crohn's disease, or Ulcerative colitis: YES NO

Please list all surgeries: _____

_____

_____

Medications: (list all medications you are taking regularly: Include over the counter, herbal or natural remedies.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pt's Signature: _____ **Staff's Signature:** _____ **RN,LPN,MA**

Date: _____ **Date:** _____

PATIENT INTAKE FOR RHEUMATOLOGY