The Christ Hospital™ Health Network

Rheumatology
NEW PATIENT QUESTIONNAIRE

Patient Name ______________________ **Date of Birth** ______________

Medical History ❑ No history of medical conditions

❑ Alcohol/Drug abuse
❑ Allergies
❑ Anemia
❑ Anxiety
❑ Arthritis/gout
❑ Asthma
❑ Bladder cancer
❑ Blood clots
❑ Blood transfusion
❑ BRCA 1 / 2
❑ Breast cancer
❑ Breast problems
❑ Cancer
❑ Cataract
❑ Cervical cancer
❑ Chronic rashes
❑ Circulation problems
❑ Colitis/bowel disease
❑ Congestive heart failure
❑ Depression
❑ Diabetes
❑ Emphysema/COPD
❑ Epilepsy/seizures
❑ Glaucoma
❑ Heart attack
❑ Heart disease
❑ Heart murmur
❑ Heartburn/GERD
❑ High blood pressure
❑ HIV/AIDS
❑ Skin cancer
❑ Stomach ulcer
❑ Stroke
❑ Thyroid disease
❑ Tuberculosis
❑ Urinary tract infection
❑ Viral hepatitis

Please list any other:

____
____
____
____
____

Rheumatologic (Arthritis) History

Do you know of any blood relative who has or had (check and give relationship):

❑ Arthritis ______________
❑ Childhood Arthritis ______________
❑ Ankylosing Spondylitis ______________
❑ Osteoarthritis ______________
❑ Lupus or "SLE" ______________
❑ Osteoporosis ______________
❑ Gout ______________
❑ Rheumatoid Arthritis ______________
❑ Other ______________

Medications

Please list both prescription and non-prescription medications you are currently taking:

Medication	Dose	Times/day	Medication	Dose	Times/day

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: ______________________________________

____

Allergies

Do you have any drug or environmental allergies? ❑ No ❑ Yes If YES, please list below and describe reaction.

______________________ Reaction: ______________________
______________________ Reaction: ______________________
______________________ Reaction: ______________________
______________________ Reaction: ______________________

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As you review the following list, please check any of those problems, which have significantly affected you.
Date of last mammogram ____________ Date of last eye exam ____________ Date of last chest x-ray ____________
Date of last Tuberculosis test ____________ Date of last bone densitometry ____________

Symptoms (Please check all that apply)

Constitutional
- ❑ Recent weight gain amount ________
- ❑ Recent weight loss 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 of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: ____________
Periods regular? ❑ Yes ❑ No
How many days apart? ____________
Date of last period? ____________
Date of last pap? ____________
Bleeding after menopause? ❑ Yes ❑ No
Number of pregnancies? ____________
Number of miscarriages? ____________

Musculoskeletal
- ❑ Morning stiffness
  Lasting how long?
  ____________ Minutes
  ____________ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in the last 6 mos.
  ____
  ____
  ____
  ____

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/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

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Surgeries

- ❑ No Surgical History
- ❑ C-Section
- ❑ Breast biopsy
- ❑ Broken bones/fractures
- ❑ CABG/Heart Bypass
- ❑ Mastectomy
- ❑ Abdominal surgery
- ❑ Hernia repair
- ❑ Gall bladder removal
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Joint replacement
- ❑ Cosmetic surgery
- ❑ Colon removal
- ❑ Brain
- ❑ Hysterectomy
- ❑ Sterilization
- ❑ Other ______________

____

____

Family Medical History – Please list relationship of family members who have/had any of the following conditions.

- ❑ Cancer ________________
- ❑ Asthma________________
- ❑ Stroke________________
- ❑ HIV/AIDS ______________
- ❑ Diabetes ______________
- ❑ Arthritis ______________
- ❑ Seizures ________________
- ❑ Migraines________________
- ❑ Heart Problems ______________
- ❑ High Cholesterol ______________
- ❑ Skin Problems ______________
- ❑ Kidney Disease ______________
- ❑ High Blood Pressure______________
- ❑ Thryoid Disease ______________
- ❑ Clotting Disorder ______________
- ❑ Alcoholism ________________

Social History

Do you drink alcohol? ❑ No ❑ Yes If YES, how many drinks per week? ______________

Do you use tobacco? ❑ No ❑ Yes ❑ Cigarettes pks/day ______ ❑ eCigarettes ❑ Cigars ❑ Pipe

Do you currently use smokeless tobacco? ❑ No ❑ Yes Have you ever used smokeless tobacco? ❑ No ❑ Yes

Do you currently use recreational drugs? ❑ No ❑ Yes ❑ I prefer to discuss with the physician

Are you sexually active? ❑ No ❑ Yes Are you using contraceptives? ❑ No ❑ Yes

Activities of Daily Living

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? ________________________________

How many people in household?____________ Relationship and age of each ________________________

____

Who does most of the housework?____________________ Who does most of the shopping? ____________________

Who does most of the yard work? ____________________

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*

1	2	3	4	5
Very Poorly	Poorly	OK	Well	Very Well

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	❑	❑	❑
Sitting Down	❑	❑	❑
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	❑	❑	❑

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Activities of Daily Living *(continued)*

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, a walker or a wheelchair (circle one)	❑	❑	❑
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 a medically related lawsuit pending? ❑ Yes ❑ No

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

Name of physician providing your primary medical care ______________________________

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, name: ____________________

Describe briefly your present symptoms: ________

____

____

____

____

Date symptoms began (approx.): __________

Diagnosis: ____________________

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

____

____

____

____

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Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:

LEFT RIGHT LEFT

LEFT RIGHT

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Please list the names of other practitioners you have seen for this problem: ____________________

____

____________________ Patient's Name

__________ Date

____________________ Physician Initials

__________ Date