Rheumatology Clinic
New Patient Questionnaire

Date:_____

Name:_____

What would you like to be called by the doctor?_____

Marital Status:_____

Please list how you would like to be contacted, if necessary:_____

Home phone:_____ Cell phone:_____

In case of emergency contact:_____

Relationship:_____ Home ph:_____ Cell ph:_____

Allergies of Drug reactions (specify drug and reaction):

Current or recent medications (include over the counter products, aspirin and vitamins):

Please list current medical problems:

Please list other doctors who are also currently treating you:

Past medical history: Please list all hospitalizations, major illnesses and surgeries

Who lives with you in your home? (Spouse, Children, In Laws, Significant other, etc)

_____

_____

_____

Your Occupation:_____

What are your hobbies?_____

Birthplace:_____ Education:_____

Have you recently traveled outside of Florida? If so where? _____

Do you get regular exercise? (describe)

Do you wear seat belts? __Always __Usually __Occasionally __Never

Smoking History:

Never smoked_____ Started (age):_____ Stopped (age):_____

On average, how many packs per day? _____

Do you drink alcoholic Beverages? _____

If yes, how many times in the last year have you had more than 4 drinks on one occasion? _____

Have you ever had a drinking problem? _____

How many cups of coffee or caffeinated drinks do you drink daily?_____

Do you use marijuana, cocaine, any street drugs or prescription drugs not prescribed for you?

_____yes _____no (Leave blank if you would rather discuss with doctor)

Family History:

Relationship	Age If living	Age of death	Health problems or cause of death
Mother			
Father			
Siblings			
Children			

***Please include cancer, diabetes, heart attack, high blood pressure, strokes, tuberculosis, and other important illnesses.**

Check if you've had	Vaccinations	Date of last one
	Tetanus	
	Influenza	
	Pneumonia	
	Hepatitis A	
	Hepatitis B	
	Shingles	
	Other	

Check if you've had	**Tests**	Date of last one:
	Colon Cancer screening	
	Colonoscopy	
	Sigmoidoscopy	
	Bone Density	
	Mammogram	
	Pap smear(women only)	
	PSA (men only)	
	Eye Exam by eye doctor	

Please check any of the following that apply to you:

____Weight change
____Fever or chills
____Fatigue
____Poor appetite
____Blurred vision
____Eye pain
____Double vision
____Eye itching
____Earache
____Hearing problem
____Hoarseness
____Ringing in ears
____Runny nose
____Nose bleeds
____Mouth sores
____Sore throat
____Chest pain
____Pounding heartbeat
____Irregular heartbeat
____Heart murmur
____Fainting
____Shortness of breath
____Cough
____Wheezing
____Snoring
____Abdominal pain
____Nausea
____Vomiting
____Diarrhea
____Constipation
____Heartburn
____Difficulty swallowing
____Rectal Bleeding
____Black tarry stools
____Blood in urine
____Painful urination
____Urinating too often
____Too much urine
____Getting up at night to urinate
____Muscle pain
____Joint pain
____Swelling in arms or legs
____Decreased joint mobility
____Skin Rash
____Itching
____Dry skin
____Breast pain or lump
____Headache
____Dizziness
____Weakness
____Pain (location_____)
____Numbness
____Stroke or seizure in past
____Depression
____Anxiety
____Stressed
____Hallucinations
____Increased thirst
____Increased hunger
____Swollen Glands
____Bruising
____Easy bleeding
____Anemia
____Asthma
____Runny Nose
____Nasal congestion
____Tuberculosis in the past
____Positive skin test for Tuberculosis
____Blood clot in the past
____Asbestos exposure
____Pancreatitis
____Gallbladder problems
____Colon Polyps
____Radiation treatments To head or neck
____Previous Herpes
____Previous gonorrhea, Syphilis or Chlamydia infection

Women only:
____Date of last menstrual period
____Abn vaginal bleeding
____Vaginal discharge
____Prev abn Pap smear
____Sexual difficulties

Men only
____Pain or lump testicle
____Discharge from penis
____Prostate problem
____Sexual difficulties