



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