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:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age if living</th>
<th>Age of death</th>
<th>Health problems or cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
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<td></td>
</tr>
<tr>
<td>Father</td>
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<td></td>
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<tr>
<td>Siblings</td>
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<td></td>
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<tr>
<td>Children</td>
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<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Check if you’ve had</th>
<th>Vaccinations</th>
<th>Date of last one</th>
<th>Check if you’ve had</th>
<th>Tests</th>
<th>Date of last one:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
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<td></td>
<td>Colon Cancer screening</td>
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<tr>
<td>Influenza</td>
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<td>Colonoscopy</td>
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<td>Pneumonia</td>
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<td>Sigmoidoscopy</td>
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<tr>
<td>Hepatitis A</td>
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<td>Bone Density</td>
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<tr>
<td>Hepatitis B</td>
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<td>Mammogram</td>
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<td></td>
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<tr>
<td>Shingles</td>
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<td></td>
<td>Pap smear (women only)</td>
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<td></td>
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<tr>
<td>Other</td>
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<td></td>
<td>PSA (men only)</td>
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<td></td>
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<td>Eye Exam by eye doctor</td>
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</tbody>
</table>
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

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