

Contact Phone Number: Home _____; Cell _____;

Other _____

Name of referral physician: _____

Name of Primary Care Physician: _____

Pharmacy: Name: _____ phone _____

Address: _____



What is your main concern to address for this visit: _____

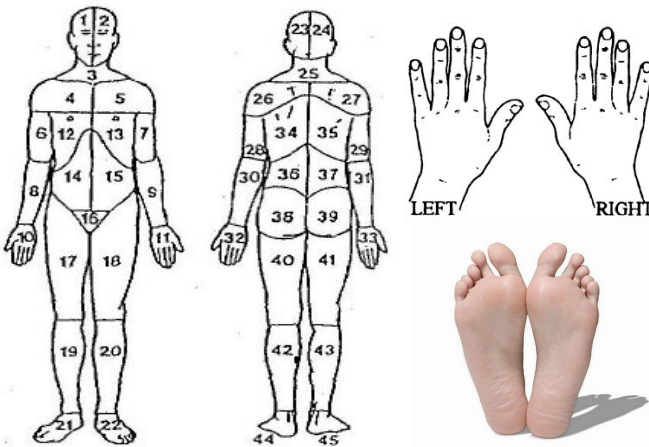
Describe the course of your chief complaints: duration _____; How long is morning stiffness: NO __, < 30 min __, < 1 hr __,

> 1 hr __; body parts involved _____;

previous evaluation by _____;

previous treatments (medical, surgical, physical therapy) _____;

Please shade the area where you have pain in the last week. Mark the following medical conditions that apply to you and family members.



	You	Parents F M	Siblings	Relatives
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots/DVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History/ Problem List

- Inflammatory eye diseases
- GERD/Acid reflex
- Cataracts
- GI bleeding
- Glaucoma
- Ulcerative colitis
- Sjogren's syndrome
- Crohn's disease
- Thyroid diseases
- Celiac disease
- COPD/Emphysema
- Kidney stones
- Pneumonia
- Kidney failure
- Asthma
- Anemia
- Cardiac disease
- Hepatitis
- Hypertension
- HIV
- Hyperlipidemia
- Tuberculosis
- Stroke
- Cancer/Leukemia
- Seizure disorders
- Migraines
- Peripheral neuropathy
- Major depression
- Myopathy
- Fracture

Past Surgical History Date

- Knee replacement
- Hip replacement
- Rotator cuff repair
- Carpal tunnel release
- Cervical spine surgery
- Lumbar spine surgery
- Knee arthroscopy

Past Procedural History Date

- Pulmonary function test PFT
- 2D-Echocardiogram
- Chest CT
- Heart Catheterization
- Stress test
- EMG/NCS
- Muscle biopsy
- Skin biopsy
- Others:

Health Maintenance

Primary Care Physician: _____
Rheumatologist: _____
Other subspecialists: _____

- Flu vaccine
- Pneumovax vaccine
- Herpes Zoster vaccine
- TB (PPD) test

- Bone densitometry
- Colonoscopy
- Mammogram
- PAP Smear

Review of Systems

General:	Weight gain (lb)	Y / N	Fatigue	Y / N
	Weight loss (lb)	Y / N	Weakness	Y / N
	Fever	Y / N	Appetite	Y / N
	Night sweats	Y / N	Morning stiffness	Y / N
Skin	Malar rash	Y / N	Hair loss	Y / N
	Discoid rash	Y / N	Brittle nails	Y / N
	Skin rash	Y / N	Nail pitting	Y / N
	Nodules/bumps	Y / N	Hardening/tightness	Y / N
	Purple fingers/toes	Y / N	Sun sensitive	Y / N
HEENT	Diplopia	Y / N	Floppy ears	Y / N
	Blurry vision	Y / N	Hearing loss	Y / N
	Red eyes	Y / N	Sinus problems	Y / N
	Dry eyes	Y / N	Voice change	Y / N
	Eye pain	Y / N	Choking	Y / N
	Dry mouth	Y / N	Sore throat	Y / N
	Oral ulcers	Y / N	Gum bleeding	Y / N
Neck	Neck pain	Y / N	Thyroid nodules	Y / N
	Stiffness	Y / N	Mass	Y / N
Respiratory	Shortness of breath	Y / N	Wheezing / Asthma	Y / N
	Cough	Y / N	Hemoptysis/cough blood	Y / N
Breast	Mass	Y / N	Color change	Y / N
	Retraction	Y / N		
Heart	Chest pain	Y / N	Leg swelling	Y / N
	Irregular heart beat	Y / N	Fainting	Y / N
Gastrointestinal	GERD/ acid reflex	Y / N	Constipation	Y / N
	Dysphagia	Y / N	Diarrhea	Y / N
	GI bleeding	Y / N	Colitis	Y / N
Female Genitourinary	Bleeding	Y / N	Rash	Y / N
	Discharge	Y / N	Ulcers	Y / N
Musculoskeletal	Joint pain	Y / N	Deformity	Y / N
	Joint swelling	Y / N	Muscle weakness	Y / N
	Stiffness	Y / N	Muscle cramp	Y / N
	Hand/foot drop	Y / N	Muscle pain	Y / N
Neurological	Tingling/numbness	Y / N	Headaches	Y / N
	Loss of gait balance	Y / N	Weakness	Y / N
	Tremor	Y / N	Frequent falls	Y / N
	Seizure	Y / N		
Psychiatric	Depression	Y / N	Sleeping disorders	Y / N
	Anxiety	Y / N	Psychosis	Y / N
Endocrine	Cold intolerance	Y / N	Diabetes	Y / N
	Heat intolerance	Y / N	Adrenal insufficiency	Y / N
Hematology	Anemia	Y / N	Swollen/ tender glands	Y / N
	Easy bruising/ bleeding	Y / N	Cancer	Y / N