# *Los Alamos Medical Care Clinic, Ltd.*

***Allergy/Immunology, Dermatology, Internal Medicine, Family Practice & Rheumatology***

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## RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____ Age: _____

Primary Care Physician: _____ Today's Date: _____

## HISTORY OF PRESENT ILLNESS

Date symptoms began: _____

Describe present symptoms: _____

Have you seen other physicians for this problem? YES NO

If yes, Whom have you seen:

| Physician Name | Specialty | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

Have you had studies and/or labs performed to evaluate for this problem? YES NO

If yes, what studies have you had done?

| Circle Which Applies | | Type of Study | Date Performed |
|---|---|---|---|
| YES | NO | MRI/MRA - Body Part | |
| YES | NO | CT Scans | |
| YES | NO | Echo Cardiogram | |
| YES | NO | Bronchoscopy | |
| YES | NO | EMG/NCS (muscle/nerve conduction study) | |
| YES | NO | Lip Biopsy | |
| YES | NO | Muscle Biopsy | |
| YES | NO | Nerve Biopsy | |
| YES | NO | Kidney Biopsy | |
| YES | NO | Liver Biopsy | |
| YES | NO | Skin Biopsy | |
| YES | NO | Bone Marrow Biopsy | |

**Serious injuries:**

| What Type | When | Outcome |
|---|---|---|
| | | |
| | | |

**Any history of broken bones:**

| Fracture Site | Age Occurred |
|---|---|
| | |
| | |

**Surgical History:**

| Surgical Procedure | Date Performed | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***LIST ANY FURTHER MEDICAL HISTORY OR SURGERIES ON BACK OF PAPER NOTED BY AN ARROW***

## WOMAN ONLY

Are you still having regular menstrual periods? YES NO

Hysterectomy? YES NO

Current hormone replacement? YES NO

Age of menopause onset? _____

History of miscarriages? YES NO

| Procedures | Date(s) of Last Testing | Physician |
|---|---|---|
| Pap Smear | | |
| Mammogram | | |
| Bone Mineral Density | | |

## SOCIAL HISTORY

**Occupation:** _____ **Martial Status:** S M D W **Age of Children:** _____

**Ethnicity:** African-American Asian Caucasian Hispanic Native American/Alaskan Native Other

**Smoking History:** YES NO Age Started: _____ Packs/day: _____ Quit? How Long? _____

**Alcohol use:** YES NO How much alcohol do you consume per day? _____ Type of exercise: _____

**Any history of intravenous (injection) drug use?** YES NO

**International Travel Past 3 years:** YES NO Country _____

**Do You Exercise?** YES NO Frequency/week: _____

**Sleep Habits:** Hours of sleep at night: __ Do you wake up feeling rested? YES NO

Insomnia? YES NO If yes, describe: _____

Have you had a sleep study? YES NO Result _____

**Do You Require use of any of the following:** Cane Walker Wheelchair Scooter

**Continued from front page:**

## Have You or a blood relative had any of the following? Please Circle

| | | | | | |
|---|---|---|---|---|---|
| Diabetes Mellitus | You | Family Member | Psoriasis | You | Family Member |
| Gout | You | Family Member | Rheumatoid Arthritis | You | Family Member |
| Heart Disease | You | Family Member | Sarcoidosis | You | Family Member |
| High Blood Pressure | You | Family Member | Thyroid Disease/Goiter | You | Family Member |
| Lupus | You | Family Member | TIA/Stroke | You | Family Member |
| Migraines | You | Family Member | Tuberculosis | You | Family Member |
| Osteoarthritis | You | Family Member | Ulcerative Colitis/Crohn's Disease | You | Family Member |
| Polymyalgia Rheumatica | You | Family Member | Uveitis or Iritis | You | Family Member |

**Other family history: (Describe relationship to blood relative and disease):**

_____

_____

## Vaccination History: Please circle Yes or No

| | | |
|---|---|---|
| Hepatitis | Yes | No |
| Pneumococcal | Yes | No |
| Shingles | Yes | No |
| BCG | Yes | No |
| FLU | Yes | No |

Other Vaccinations:

Date of last Chest Xray:_____

Date of last Tuberculosis test:_____ Date of Hepatitis test?_____

Date of last Eye Exam:_____ Who is your Eye Doctor?_____

Other Specialists you see: _____

_____

## PAST MEDICAL HISTORY

Please list your medical problems:

1._____

2._____

3._____

4._____

5._____

6._____

8._____

9._____

10._____

11._____

12._____

13._____

# MEDICATIONS

**Medication Allergies:**

| Medication | Reaction (i.e nausea, vomit, rash, headache, etc.) |
|---|---|
| | |
| | |

**Present:** List any medications you are taking at this time. Include over the counter, vitamins, supplements

| Name of Drug | Dosage (include strength and times per day) |
|---|---|
| | |
| | |
| | |
| | |
| | |

***YOU MAY CONTINUE ON THE BACK OF THIS SHEET OR ADD YOUR OWN LIST OF MEDS THAT YOU MAY HAVE BROUGHT WITH YOU**
***Please indicate with an arrow if you are continuing medications or allergies on the back of this sheet***

**Past:** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, the results of taking the medication, and list any reactions you may have had.

| Drug - NSAIDS | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Ansaid (Fubipohen) | Helped A Lot | Some | None | |
| Arthrotec | Helped A Lot | Some | None | |
| Aspirin | Helped A Lot | Some | None | |
| Celebrex | Helped A Lot | Some | None | |
| Indocin (Indometancin) | Helped A Lot | Some | None | |
| Lodine (Etodolac) | Helped A Lot | Some | None | |
| Mobic | Helped A Lot | Some | None | |
| Motrin (Ibuprofen) | Helped A Lot | Some | None | |
| Naproxen (Naprosyn/alleve) | Helped A Lot | Some | None | |
| Oruvail (Ketoprofen) | Helped A Lot | Some | None | |
| Oxaprozin (Daypro) | Helped A Lot | Some | None | |
| Priroxicam (Feldene) | Helped A Lot | Some | None | |
| Relafen (Nambumetone) | Helped A Lot | Some | None | |
| Sulindac (Clinoril) | Helped A Lot | Some | None | |
| Tolmentin (Tolectin) | Helped A Lot | Some | None | |
| Voltaren (Diclofenac) | Helped A Lot | Some | None | |

| Drug - Muscle Relaxers | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Cyclobenzaprine (Flexeril) | Helped A Lot | Some | None | |
| Robaxin | Helped A Lot | Some | None | |
| Skelaxin | Helped A Lot | Some | None | |
| Zanaflex | Helped A Lot | Some | None | |
| Other: | Helped A Lot | Some | None | |

| Drug - Other Pain Relievers | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Ultram | Helped A Lot | Some | None | |
| Ultracet | Helped A Lot | Some | None | |
| Tylenol | Helped A Lot | Some | None | |
| Other: | Helped A Lot | Some | None | |

| Drug - Rheumatoid Arthritis | Results of Medication | | | Reaction |
|---|---|---|---|---|
| Arava | Helped A Lot | Some | None | |
| Methotrexate | Helped A Lot | Some | None | |
| Sulfasalazine (Azulfidine) | Helped A Lot | Some | None | |
| Enbrel | Helped A Lot | Some | None | |
| Humira | Helped A Lot | Some | None | |
| Remicade | Helped A Lot | Some | None | |
| Simponi | Helped A Lot | Some | None | |
| Cimzia | Helped A Lot | Some | None | |
| Orencia | Helped A Lot | Some | None | |
| Rituxan | Helped A Lot | Some | None | |
| Gold | Helped A Lot | Some | None | |

| Drug - Other | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Cytoxan (Cyclophosphamide) | Helped A Lot | Some | None | |
| Imuran (Azathioprine) | Helped A Lot | Some | None | |
| Plaquenil | Helped A Lot | Some | None | |
| Prednisone / Medrol | Helped A Lot | Some | None | |

| Drug | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Neurontin | Helped A Lot | Some | None | |
| Lyrica | Helped A Lot | Some | None | |
| Cymbalta | Helped A Lot | Some | None | |
| Savella | Helped A Lot | Some | None | |

| Drug - Osteoporosis | Results of Medication | | | Reactions |
|---|---|---|---|---|
| Fosamax | Helped A Lot | Some | None | |
| Actonel | Helped A Lot | Some | None | |
| Boniva | Helped A Lot | Some | None | |
| Reclast | Helped A Lot | Some | None | |
| Forteo | Helped A Lot | Some | None | |
| Evista | Helped A Lot | Some | None | |

# LAMCC Rheumatology- REVIEW OF SYMPTOMS

PATIENT NAME:_____DOB:_____DATE:_____

## CHECK/CIRCLE APPLICABLE:

GENERAL:

- Recent weight gain:
  Amount?_____
- Recent weight loss
  Amount?_____
  Over what time:_____
  Purposeful? Y / N
- Fatigue
- Fever
- Night Sweats/Drenching

EYES:

- Dry eyes
- Irritation
- Eye inflammation-
  Iritis/uveitis/scleritis
- Vision loss/changes

ENMT:

- Hearing loss
- Ringing/tinnitus
- Nasal ulcers/polyps
- Mouth ulcers/sores
- Dry mouth
- Difficulty swallowing
- Hoarseness
- Thyroid problems

CARDIOVASCULAR:

- Chest pain
- Pericarditis
- Palpitations/Irreg.heart beat
- Heart murmur
- Heart Attack
- Cardiac Catheterization
- Heart Failure

PULMONARY:

- Cough
- Wheezing
- Shortness of Breath
- Sleep Apnea
- Coughing up blood
- Pleurisy
- Asthma
- Tuberculosis/ Positive TB skin test

GASTROINTESTINAL:

- Abdominal pain
- Vomiting of blood/coffee ground like substance
- Bloody or dark stool
- Persistant diarrhea
- Constipation
- Heartburn/Reflux
- Ulcers
- H.Pylori Diagnosis
- Colonoscopy
  Date:_____
- Endoscopy
  Date:_____

- Pancreatitis
- Liver Disease/Jaundice
- Hepatitis:
  Type:_____
  When:_____
  Treated:_____

- Gallbladder disease/removed

GENITOURINARY:

- Blood in urine
- Protein in urine
- Kidney disease
- Kidney failure
  Dialysis: Y / N
- Kidney stones
- Kidney Biopsy
- Sexually Transmitted Disease
- Discharge from Vagina or Penis
- Ulcers on Vagina or Penis
- Have you ever seen a kidney doctor or Urologist?

SKIN:

- Psoriasis
- Sun sensitivity (rash)
- Hair loss- extensive
- Raynauds: color changes to hands and feet in the cold
- Other: rash, nodules, lesions, ulcers: Where:_____
- Have you or do you see a Dermatologist?
  Whom do you see? _____

NERVOUS SYSTEM:

- Numbness/Tingling
  Location:_____
- Seizures
- Strokes
- Peripheral Neuropathy
- Migraines
- Other Headaches/jaw pain
- Multiple Sclerosis
- Unusual Memory Loss
- Depression
- Psychosis
- Other Psychiatric Diagnosis
  Type:_____
- Sleep Disturbances/restless sleep

HEMATOLOGIC/LYMPHATIC:

- Anemia
- Low white blood count
- Low platelets
- Blood clots- legs, lungs, other
- Excessive bleeding
- Transfusions
- Swollen Glands
- Bone marrow Biopsy
- Biopsy Other tissue/organ
- History of blood disorders or cancers of any kind?
  Please Describe: _____

ALLERGY/IMMUNOLOGY:

- Facial swelling
- Sinus disease/polyps
- Hives
- Allergy shots

MUSCULOSKELETAL:

- Morning Stiffness
  Lasts: _____hrs/min
- Joint pain
- Joint swelling
- Muscle pain/tenderness
- Muscle weakness
- Joints that are the most painful:
  List below: