

# BERGEN

## GASTROENTEROLOGY • MEDICAL ASSOCIATES

*committed to the highest level of patient care*

### RHEUMATOLOGY NEW PATIENT HISTORY FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_ MRN #: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status:  Never married  Married  Divorced  Separated  Widowed  Partnered

Who said you needed a rheumatologist? \_\_\_\_\_

Name of your primary care physician: \_\_\_\_\_

Describe briefly your present symptom(s):

When did your symptoms start?

What diagnosis have you been given, if any?

Please list the practitioners & specialities you have seen for this:

What makes you better?

What makes you worse?

On a scale of 1 (no pain) to 10 (worst pain), how bad is your pain? \_\_\_\_\_

Previous treatment for this problem (include physical therapy, surgery, alternative treatments, and injections):

### PAST MEDICAL HISTORY

Do you have now or did you have ever: check if "yes"

- |   |   |                                      |  |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Stomach or Peptic Ulcer    | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Angina          |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Glaucoma        |
| <input type="checkbox"/> Hypothyroidism Goiter      | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Cataracts       |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Jaundice    | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Hiv or Aids | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Kidney or Bladder Stones   | <input type="checkbox"/> Depression     | <input type="checkbox"/> Anemia      | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Pulmonary Embolism         | <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Leukemia    | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Crohn's Disease or Colitis | <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Lymphoma    | <input type="checkbox"/> Cancer (Type)   |

Other significant illnesses (please list):

Any previous fractures?  No  Yes

Describe: \_\_\_\_\_

Any other serious injuries?  No  Yes

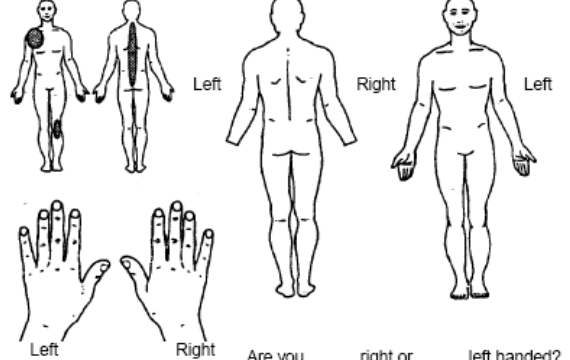
Describe: \_\_\_\_\_

Physician Initials: \_\_\_\_\_

Jeff Chung, M.D.

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Are you \_\_\_\_\_ right or \_\_\_\_\_ left handed?  
(Which hand do you sign your name with?)

**RHEUMATOLOGIC (ARTHRITIS)**

At any time have you or a blood relative had any of the following? (check if "yes")

	You	Relative	Relationship to you
Arthritis unknown type	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
"SLE" or Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	
Childhood arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	

**FAMILY HISTORY**

	Age	Health Problems (if living)	Age at death (if deceased)	Cause(s) of
Father				
Mother				

Siblings


Children


**PERSONAL HISTORY**

What occupation(s) have you had? \_\_\_\_\_

If not working, are you:  retired  disabled  on sick leave

When did this disability begin? \_\_\_\_\_

Do you receive disability or SSI?  Yes  No If yes, for what disability? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke?  Yes  No How much/often? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much/often? \_\_\_\_\_

Usual drink: \_\_\_\_\_

Has anyone ever told you to cut down on your drinking?

Yes  No

Do you use drugs for reasons that are not medical?

Yes  No

If yes, please list: \_\_\_\_\_

Do you get enough sleep at night?  Yes  No

Do you wake up feeling rested?  Yes  No

Physician Initials: \_\_\_\_\_

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**PREVIOUS SURGERIES/OPERATIONS**

	Type	Year	Reason
1			
2			
3			
4			
5			

**MEDICATIONS**

What medication allergies do you have? What type of allergic reaction was it?

Please list below any prescribed and non-prescribed medicine that you are taking. Include vitamins, glucosamine, laxatives, calcium, etc.

**SYSTEMS REVIEW**

Date of last eye exam: \_\_\_\_\_ Date of last chest x-ray: \_\_\_\_\_ Date of last bone density test: \_\_\_\_\_

Result of last TB (PPD) test:  Never done  Negative  Positive Date test performed: \_\_\_\_\_

**General**

- Recent weight gain: how much \_\_\_\_\_  Fatigue  Fever  
 Recent weight loss: how much \_\_\_\_\_  Weakness  Night sweats

**Muscle/Joints/Bones**

- Morning stiffness  Joint pain  Muscle weakness  
 Lasting how long? (minutes/hours)  Joint swelling

List joints affected in the last 6 months:

**Ears**

- Ringing in ears  Loss of hearing

**Eyes**

- Pain  Change or loss of vision  Dryness  
 Redness  Double or blurred vision  Feels like something in eye

**Mouth**

- Sore tongue  Sores in mouth  Dryness  
 Bleeding gums  Loss of taste  Recent increase in tooth cavaties

**Nose**

- Nosebleeds  Loss of smell

**Throat**

- Frequent sore throats  Difficulty with swallowing  Excessive thirst  
 Hoarseness  Jaw pain while chewing

Physician Initials: \_\_\_\_\_

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**Neck**

- Swollen glands  Tender glands

**Heart and Lungs**

- Coughing up blood  Shortness of breath  Pain in chest  
 Wheezing  Difficulty in breathing  Irregular heart beat  
 Cough  Swollen legs or feet  Sudden changes in heart

**Stomach and Intestines**

- Black stools  Heartburn or gastritis  Yellow jaundice  
 Blood in stools  Increasing constipation  Nausea  
 Vomiting of blood-“coffee grounds”  Persistent diarrhea  Stomach pain relieved by food or milk

**Nervous system**

- Severe or constant headaches  Fainting/loss of consciousness  Memory loss  
 Dizziness  Numbness/tingling of digits  Muscle weakness

**Psychiatric**

- Sadness  Difficulty falling asleep  
 Excessive worries  Difficulty staying asleep

**Osteoporosis**

- Getting shorter  Frequent falls  Low calcium intake  
 Past cortisone intake  Scoliosis

**Blood/Immune**

- Frequent infections of any type  Bleeding tendency  Blood transfusion

**Skin**

- Easy bruising  Non-healing ulcers  Hair loss  
 Rash or hives  Skin tightness  Color changes of hands or feet in the cold (Raynaud’s)  
 Sun sensitive or sun allergy  Nodules/bumps

**Kidney/Urine Bladder**

- Difficult urination  Pus in urine  Vaginal dryness  
 Pain or burning on urination  Blood in urine  Rash/ulcers  
 Frequent urination including night  Cloudy, “smoky” urine  Sexual difficulties  
 Discharge from penis/vagina  Prostate trouble

**For women only:**

Age when periods began: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Have you reached menopause? Yes No If yes, at what age? \_\_\_\_\_

Have you had hormones? Yes No

Date of last Pap smear: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

If you are still having periods:

Are they regular? Yes No How many days apart? \_\_\_\_\_

**SAVE FORM**

**SUBMIT FORM**

Physician Initials: \_\_\_\_\_

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