

Eversmeyer-Perdue, Arthritis & Rheumatology

4315 Houma Blvd, Suite 303

Metairie, LA 70003

phone: 504-889-5242; fax: 504-780-9251

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Primary Care MD info:

Name of practitioner referring you:

Name: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Fax: \_\_\_\_\_

**Past Medical/Surgical History:** Please include any conditions for which you have *ever* taken medications, been hospitalized, or have needed to seek medical attention.

Past Medical History:

Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgical History:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on back if need more space)

**Family History:** (Please include relation and disease)

Has anyone in your family been diagnosed with any autoimmune disease, such as lupus (SLE), rheumatoid arthritis (RA), vasculitis, ankylosing spondylitis, or other?

\_\_\_\_\_

Any relative suffered from psoriasis (skin rash) or inflammatory bowel disease (Crohn's Disease)?

\_\_\_\_\_

Please list medical history of your parents and siblings:

Include hypertension, diabetes, heart disease, stroke, and cancer (including type of cancer).

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Sister(s): \_\_\_\_\_ Brother(s): \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

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**Social History:**

What is your occupation? Full or part? (If retired or disabled, include date of retirement/disability and prior occupation.)

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Former occupations? (include any occupational hazards if applicable)

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Tobacco use (cigarettes, cigars, pipe, chewing)? If not, have you ever? When did you quit?  
(Please include how much per day and for how long.)

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Do you exercise? (If so, what type and how often per week?)

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Consume alcohol? (If so, what type? How much? And how often?)

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Do you consume caffeine products including coffee, tea, or soda? (If so, what type and how many cups per day?)

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Current marital status (single, married, divorced, or widowed)? Any children (include # of sons and # of daughters)?

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If a woman, any history of miscarriages? If so, how many and at what week of pregnancy?

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Have you ever used **illegal** IV drugs even once in the past?

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Have you received any blood product transfusions ever in the past?

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Have you ever been treated for a sexually transmitted disease (STD)? Any high risk sexual behavior?

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Any recent travel outside of the USA? Where?

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Any exposure to TB (tuberculosis) that you are aware of? If so, when and were you treated?

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Please check any of the following items which have *significantly* affected you over **THE LAST WEEK**:

**Constitutional:**

- Chills/Rigors
- Fatigue
- Fever
- Night sweats
- Weight changes, if so gain or loss? How much? Time frame? \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat:**

- Visual loss
- Blurry vision
- Double vision
- Dry mouth
- Dry eyes
- Problems swallowing
- Frequent nose bleeds
- Eye Pain
- Facial pain
- Hearing loss
- Hoarse voice
- Nasal drainage
- Sores in mouth
- Eye Redness
- Frequent sinusitis
- Sore throat
- Ringing

**Respiratory:**

- Cough
- Coughing up blood
- Breathing problems when lying flat
- Pain with breathing
- Shortness of breath
- Wheezing

**Cardiovascular:**

- Chest pain
- Pain in calves with walking
- Leg/feet swelling
- Irregular heart beat
- Raynaud's

**Gastrointestinal:**

- Abdominal cramping
- Abdominal pain
- Bloating
- Bright red blood in stool
- Constipation
- Diarrhea
- Heart burn
- Loss of appetite
- Nausea
- Vomiting

**Genitourinary:**

- Pain on urination
- Genital lesions/ulcers
- Bloody urine
- Frequent urination at night
- Pain in sex organs
- Increased urination
- Urinary incontinence

**Metabolic/endocrine:**

- Cold intolerance
- New hair loss
- Heat intolerance
- Increased facial hair
- Hot flashes
- Excessive thirst

**Neurologic:**

- Confusion/disorientation
- Dizziness
- Numbness in hands/feet
- Weakness of hands/feet
- New gait disturbance
- Headache
- Memory loss
- Seizures
- Fainting
- Tingling of hands/feet
- Tremors

**Psychiatric:**

- Anxiety
- Depression
- Emotionally labile
- Hallucinations
- Insomnia
- Suicidal thoughts

**Immunology:**

- Seasonal allergies
- Frequent infections

**Dermatologic:**

- Acne
- Hives
- Itchy skin
- Nail changes
- Sunlight sensitivity
- Psoriasis
- Rash

**Musculoskeletal:**

- Back pain
- Joint pain
- Joint swelling
- Muscle cramping
- Muscle weakness
- Muscle pain
- Neck pain

**Hematological:**

- Easy bleeding
- Easy bruising
- Enlarged lymph nodes
- Hx of blood clots?

**Any other symptom not addressed? Explain.**

\_\_\_\_\_  
\_\_\_\_\_

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