Sierra Nevada Rheumatology, LLC

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New Patient History Form

PATIENT NAME ______________________________ DOB ____________ DATE ____________

PRIMARY CARE PHYSICIAN ______________________________ CHART #____________

Briefly tell us the reason for your visit today:______________________________

____

PAST MEDICAL HISTORY
List your current medical problems (with year of diagnosis) and any hospitalizations.

CURRENT MEDICAL PROBLEMS:	YEAR	CURRENT MEDICAL PROBLEMS:	YEAR
1.			
2.			
3.			
4.			

ANY PREVIOUS FRACTURES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

ANY OTHER SERIOUS INJURIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

HAVE YOU BEEN TESTED FOR:

Hepatitis B: ☐ Yes ☐ No If Yes, Result/Year:__________	Hepatitis C: ☐ Yes ☐ No If Yes, Result/Year:__________	HIV: ☐ Yes ☐ No If Yes, Result/Year:__________

LIST SURGERIES YOU WOULD CONSIDER SIGNIFICANT:	YEAR	LIST SURGERIES YOU WOULD CONSIDER SIGNIFICANT:	YEAR
1.			
2.			
3.			
4.			

Social History

Do you smoke? ☐ Yes ☐ No	Number of packs per day?____________	How many years?____________
Do you currently drink alcohol? ☐ Yes ☐ No	How often?____________	Previous regular use? ☐ Yes ☐ No

Do you use any substances such as cocaine or marijuana? ☐ Yes ☐ No
If yes, please list:______________________________How often?______________________________

Are you employed? ☐ Yes ☐ No If yes, occupation?______________________________

On Disability? ☐ Yes ☐ No If yes, reason?______________________________

Family History
Please check and indicate which family member in the space provided.

☐ Rheumatoid Arthritis	☐ Gout	☐ Ankylosing Spondylitis	☐ Diabetes
☐ Lupus	☐ Osteoarthritis	☐ Psoriasis	☐ High Blood Pressure
☐ Fibromyalgia	☐ Osteoporosis	☐ Crohn’s/Ulcerative Colitis	☐ Tuberculosis

Review of Systems
Please check **Y** (Yes) or **N** (No) and fill in the blanks where appropriate.

CONSTITUTIONAL
Y N
- ☐ ☐ Recurring Fever
- ☐ ☐ Weight Loss
- ☐ ☐ Tired all the Time
- ☐ ☐ Feel Weak all Over
- ☐ ☐ Heat/Cold Intolerance

ENDOCRINE
Y N
- ☐ ☐ Thyroid Disease
- ☐ ☐ Change in Hat Size

EYES
Y N
- ☐ ☐ Frequent Red Eyes
- ☐ ☐ Frequent Eye Pain
- ☐ ☐ Chronic Eye Dryness
- ☐ ☐ Recent Vision Changes

ENT
Y N
- ☐ ☐ Chronic Dryness in Mouth
- ☐ ☐ Frequent Mouth Ulcers
- ☐ ☐ Chronic Hoarseness
- ☐ ☐ Hearing Loss

RESPIRATORY
Y N
- ☐ ☐ Chest hurts with a deep breath
- ☐ ☐ Frequently feel short of breath
- ☐ ☐ Frequent Coughing
- ☐ ☐ Frequent Wheezing
- ☐ ☐ Snoring
- ☐ ☐ Recurrent Pneumonia
- ☐ ☐ Asthma

CARDIOVASCULAR
Y N
- ☐ ☐ Chest pain with exertion
- ☐ ☐ Feel short of breath with mild exertion
- ☐ ☐ Recent Fainting
- ☐ ☐ Frequent Ankle Swelling

GASTROINTESTINAL
Y N
- ☐ ☐ Heartburning
- ☐ ☐ Frequent Nausea
- ☐ ☐ Crohn's/Ulcerative Colitis
- ☐ ☐ IBS (Irritable Bowel)
- ☐ ☐ Blood in stool or black/tarry stool

URINARY
Y N
- ☐ ☐ Pain When Urinating
- ☐ ☐ Blood in Urine
- ☐ ☐ Kidney Stones
- ☐ ☐ Frequent Bladder Infections
- ☐ ☐ Frequent Genital Ulcers

Number of times pregnant:______________________

Number of live births: ______________________

Number of miscarriages: ______________________

Number of abortions:______________________

Method of contraception: ______________________

MUSCULOSKELETAL
Y N
- ☐ ☐ Pain all over (muscles/joints)
- ☐ ☐ Joint Pains. Which ones? ______________________
- ☐ ☐ Muscle Pains. Location(s)? ______________________
- ☐ ☐ Body stiffness when you wake up. Lasts how long? ____________
- ☐ ☐ Joints swell. Which ones? ______________________
- ☐ ☐ Fingers or toes swell up like hot dogs

SKIN
Y N
- ☐ ☐ Pigment Changes
- ☐ ☐ Psoriasis
- ☐ ☐ Recurring Rashes. Where? ______________________
- ☐ ☐ Frequent Itching
- ☐ ☐ Brief sun exposure causes a skin rash
- ☐ ☐ Recent finger or toe nail changes
- ☐ ☐ All color drains out of fingertips when it's cold
- ☐ ☐ Significant hair loss

HEMATOLOGIC
Y N
- ☐ ☐ Frequent Swollen Glands
- ☐ ☐ Treated for a blood clot. Body part? ______________________
- ☐ ☐ Excessive Bleeding
- ☐ ☐ Frequent Nosebleeds
- ☐ ☐ Excessive Bruising

NEUROLOGIC
Y N
- ☐ ☐ Headaches
- ☐ ☐ Seizures
- ☐ ☐ Numbness. Body Part(s): ______________________
- ☐ ☐ Burning Sensation. Body Part(s): ______________________
- ☐ ☐ Pins-and-needle sensation. Body Part(s): ______________________
- ☐ ☐ Recent weakness of a body part: ______________________

PSYCHIATRIC
Y N
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Confusion
- ☐ ☐ Sleep Disorder: ______________________
- ☐ ☐ Sleep Problems: ☐ Falling Asleep ☐ Staying Asleep

CURRENT MEDICATIONS
Please list all medications including prescription, over-the-counter and vitamins

DRUG ALLERGIES ☐ **YES** ☐ **NO** **TO WHAT?** **TYPE OF REACTION?**

NAME OF MEDICATION	DOSAGE	FREQUENCY

HERBAL OR NATURAL SUPPLEMENT	DOSAGE	FREQUENCY

PATIENT SIGNATURE ______________________ DATE ____________

PHYSICIAN SIGNATURE ______________________ DATE ____________

Thank you for allowing us to assist you with your health care needs. We look forward to serving you.