ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

RHEUMATOLOGY INTAKE FORM

DEMOGRAPHICS:

Patient Name: ______________________ DOB: ______________ Sex: ❑ Male ❑ Female
Highest Education level: ______________________ Ht/Wt: ______________ Marital Status: ______________
Occupation: ______________________ Hrs worked/wk: ______________ Birthplace: ______________
Referred by: ______________________ PCP: ______________ Hand Dominance: ❑ Right ❑ Left

REASON FOR VISIT:

What is the main reason for your visit today: ____
____
____

PAIN DIAGRAM: Please shade all the locations of your pain **over the past week** on the **body figures**

R L L R

Describe briefly your present symptoms:

____
____
____
____
____

Describe previous treatments for this problem:

____
____
____
____
____

Date symptoms began (approximate): ______________

How severe is your pain? (Circle #)

0	1 2 3	4 5 6 7	8 9 10
No Pain	Mild	Moderate	Severe

RHEUMATOLOGIC (ATHRITIS) HISTORY: At any time have you or a blood relative had any of the following?

You		Relative Name/ Relationship	You		Relative Name/ Relationship
❑	Arthritis (unknown)		❑	Lupus or “SLE”	
❑	Osteoarthritis		❑	Rheumatoid Arthritis	
❑	Gout		❑	Ankylosing Spondylitis	
❑	Childhood Arthritis		❑	Osteoporosis	

Other arthritis conditions: ____

THIRD PARTY LIABILITY:

If this was due to a motor vehicle accident, do you have an accident policy: ❑ No ❑ Yes.
Are you seeking reimbursement from any party or insurance company for the treatment of this injury? ❑ No ❑ Yes.
Do you have any litigation (legal action/court case) pending for this problem/injury? ❑ No ❑ Yes.
If Yes on any of these please provide details: ____

DIAGNOSTIC TESTS:

Please check box and list date if you had any of the following tests performed for this problem:

❑ Date of last Tuberculosis test: ____________________

❑ CT Scan____________________

❑ Date of last Bone Densitometry: ____________________

❑ Ultrasound____________________

❑ Xray ____________________

❑ Myelogram____________________

❑ EMG ____________________

❑ MRI ____________________

❑ Other____________________

❑ Other____________________

ALLERGIES:	ADDITIONAL INFORMATION:
Please list any/all drug and food allergies:	Please list the names of the other practitioners you have seen for this problem:
1. ______	1. ______
2. ______	2. ______
3. ______	3. ______
4. ______	4. ______
5. ______	5. ______

SYSTEMS REVIEW: Please check any problems which have significantly affected you

Ears-Nose-Mouth-Throat	Cardiovascular	Respiratory	Gastrointestinal
❑ Sores in mouth ❑ Dryness of mouth	❑ High blood pressure ❑ Heart murmurs	❑ Coughing of blood	❑ Blood in stools ❑ Heartburn
Genitourinary	**Integumentary**	**Hematologic**	**Neurological System**
❑ Rash/ulcers	❑ Sun sensitive (sun allergy) ❑ Hair loss ❑ Color changes of hands or feet in the cold	❑ Swollen glands ❑ Tender glands ❑ Anemia	❑ Loss of consciousness ❑ Night sweats

Musculoskeletal	For Women Only
❑ Morning stiffness: Lasting how long _____ minutes _____ hrs	❑ Vaginal Dryness ❑ Date of last period: ______ ❑ # of pregnancies: _______ ❑ Number of miscarriages: _______

PRESENT MEDICATION: List any medications you are taking. Include such items as aspirin, vitamins, laxatives etc

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A lot	Some	Not at all
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑

PAST MEDICATION: Please review the list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. Record your comments in the space provided.

Drug Names/Dose	Length of time	Please check: Helped? A lot	Some	Not at all	Reactions
Non-steroidal Anti-Inflammatory Drugs (NSAIDS)		❑	❑	❑	

Circle any you have taken in the past

Flurbiprofen Diclofenac+misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Meclofenamate Etodolac Choline magnesium trisalcylate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Diclofenac

Pain Relivers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Tramadol		❑	❑	❑	

Tylenol with codeine		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Actemra		❑	❑	❑	
Azathioprine		❑	❑	❑	
Benlysta		❑	❑	❑	
Cimzia		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Enbrel		❑	❑	❑	
Humira		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Kevzara		❑	❑	❑	
Methotrexate		❑	❑	❑	
Orencia		❑	❑	❑	
Otezla		❑	❑	❑	
Remicade		❑	❑	❑	
Simponi		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Xeljanz		❑	❑	❑	
Other:		❑	❑	❑	
Osteoporosis Medications					
Alendronate		❑	❑	❑	
Estrogen		❑	❑	❑	
Forteo		❑	❑	❑	
Prolia		❑	❑	❑	
Raloxifene		❑	❑	❑	
Reclast Infusion		❑	❑	❑	
Risedronate		❑	❑	❑	
Tymlos		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Allopurinol		❑	❑	❑	
Colchicine		❑	❑	❑	
Febuxostat		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Other					
Cortisone/Prednisone		❑	❑	❑	
Tamoxifen		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Please list Supplements: ____

Have you participated in any clinical trials for new medications ❑ Yes ❑ No. If Yes List: ______________________

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I certify that to the best of my knowledge, all information listed above is true. I further certify that I have not falsified or intentionally omitted any information related to my health or past medical history.

Signature of patient/guardian: ______________________________ Date: ______________