



ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

RHEUMATOLOGY INTAKE FORM

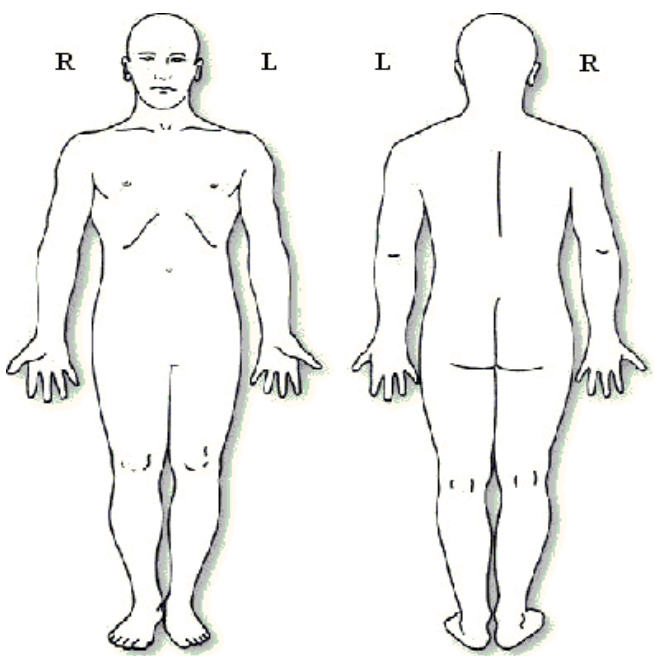
DEMOGRAPHICS:

Patient Name: _____	DOB: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Highest Education level: _____	Ht/Wt: _____	Marital Status: _____
Occupation: _____	Hrs worked/wk: _____	Birthplace: _____
Referred by: _____	PCP: _____	Hand Dominance: <input type="checkbox"/> Right <input type="checkbox"/> 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



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
<input type="checkbox"/>	Arthritis (unknown)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	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:	
<input type="checkbox"/> Date of last Tuberculosis test: _____	<input type="checkbox"/> CT Scan _____
<input type="checkbox"/> Date of last Bone Densitometry: _____	<input type="checkbox"/> Ultrasound _____
<input type="checkbox"/> Xray _____	<input type="checkbox"/> Myelogram _____
<input type="checkbox"/> EMG _____	<input type="checkbox"/> MRI _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> 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 <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Dryness of mouth	Cardiovascular <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmurs	Respiratory <input type="checkbox"/> Coughing of blood	Gastrointestinal <input type="checkbox"/> Blood in stools <input type="checkbox"/> Heartburn
Genitourinary <input type="checkbox"/> Rash/ulcers	Integumentary <input type="checkbox"/> Sun sensitive (sun allergy) <input type="checkbox"/> Hair loss <input type="checkbox"/> Color changes of hands or feet in the cold	Hematologic <input type="checkbox"/> Swollen glands <input type="checkbox"/> Tender glands <input type="checkbox"/> Anemia	Neurological System <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Night sweats
Musculoskeletal <input type="checkbox"/> Morning stiffness: Lasting how long _____ minutes _____ hrs	For Women Only <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> # of pregnancies: _____		
		<input type="checkbox"/> Date of last period: _____ <input type="checkbox"/> 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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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?			Reactions
		A lot	Some	Not at all	
Non-steroidal Anti-Inflammatory Drugs (NSAIDS)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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 Relievers					
Acetaminophen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tramadol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

Please list Supplements: _____

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

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: _____