

CHEYENNE MEDICAL SPECIALISTS, P.C.
5050 POWDERHOUSE ROAD
CHEYENNE, WY 82009
New Patient History Form-Rheumatology

Name: _____ Date of Birth: _____

Referring Physician: _____

This questionnaire is to get information that would help in the assessment of your health problem(s). Please try to answer each question, even if you do not think it is related to you at this time. Thank you.

1. PAST MEDICAL HEALTH:

Do you now or have you ever had: (check if "Yes")

- | | | |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Angina | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Other heart disease (please describe) _____ | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD / Emphysema | <input type="checkbox"/> Acid reflux or GERD |
| <input type="checkbox"/> Peptic ulcer Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Crohn's Disease/ Ulcerative Colitis |
| <input type="checkbox"/> Blood clots in legs or lungs | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety or panic disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy (Seizures) | |
| <input type="checkbox"/> Neurological disease such as multiple sclerosis, Parkinson's disease | | |
| <input type="checkbox"/> Degenerative disk disease (back disease, spinal stenosis or severe chronic back pain) | | |
| <input type="checkbox"/> Visual impairment such as cataract, glaucoma, or macular degeneration | | |
| <input type="checkbox"/> Hearing impairment such as very hard of hearing even with hearing aids | | |
| <input type="checkbox"/> Cancer (please describe) _____ | | |
| <input type="checkbox"/> Other significant illnesses (please list) _____ | | |

Please list any surgeries or operations that you have had: _____

2. RHEUMATOLOGIC (ARTHRITIS) HISTORY:

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

	Yourself	Relative	Relationship
Arthritis (unknown type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Childhood arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Degenerative disk disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus or SLE	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polymyositis / Dermatomyositis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vasculitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physician Initials _____

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Genito-urinary:

- Increased urinary frequency Burning or pain on urination Blood in urine
 For women only:
 Do you have menstrual period? Yes No Number of pregnancies _____ Miscarriages _____

Neurologic:

- Headaches Numbness or tingling in hands/feet Memory loss

Skin:

- Butterfly or malar rash on face Other rashes Rash or feeling sick after going out in sun
 Bald patches on scalp, or clumps of hair on pillow Color changes in fingers with cold exposure

Hematologic:

- Ease bruisibility Ease of bleeding Any h/o low blood counts (e.g low platelets)

Psychiatric:

- Anxiety Depression Stress

Musculoskeletal:

- Joint pain Joint swelling Muscle tenderness Muscle weakness

Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
<u>LEFT FINGERS</u>	___0	___1	___2	___3	<u>RIGHT FINGERS</u>	___0	___1	___2	___3
<u>LEFT WRIST</u>	___0	___1	___2	___3	<u>RIGHT WRIST</u>	___0	___1	___2	___3
<u>LEFT ELBOW</u>	___0	___1	___2	___3	<u>RIGHT ELBOW</u>	___0	___1	___2	___3
<u>LEFT SHOULDER</u>	___0	___1	___2	___3	<u>RIGHT SHOULDER</u>	___0	___1	___2	___3
<u>LEFT HIP</u>	___0	___1	___2	___3	<u>RIGHT HIP</u>	___0	___1	___2	___3
<u>LEFT KNEE</u>	___0	___1	___2	___3	<u>RIGHT KNEE</u>	___0	___1	___2	___3
<u>LEFT ANKLE</u>	___0	___1	___2	___3	<u>RIGHT ANKLE</u>	___0	___1	___2	___3
<u>LEFT TOES</u>	___0	___1	___2	___3	<u>RIGHT TOES</u>	___0	___1	___2	___3
<u>NECK</u>	___0	___1	___2	___3	<u>BACK</u>	___0	___1	___2	___3

**1. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?
 Place a mark on the line below:**

FATIGUE IS **○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○** FATIGUE IS
 NO PROBLEM 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 MAJOR PROBLEM

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