Franciscan PHYSICIAN NETWORK

Rheumatology & Osteoporosis Specialists **New Patient History**

Patient's Name_____ DOB_____ **MRN**_____**(office use only)**

Referring physician_____ Primary physician_____

Orthopedic surgeon_____

What is the chief problem that brings you to this office? (Please be brief) _____

_____

How long have you had this problem? _____

What diagnosis have you been given? _____

Previous treatment? (Include physical therapy, surgery, injections) _____

_____

Please list the names, phone numbers & faxes (if known) of any other physicians or providers you have seen for this problem: _____

_____

Arthritis History

Have you experienced any of the following in the last several weeks? (circle yes or no)

a. Joint pain Yes No If yes, which joints and how severe?_____

_____

b. Joint swelling Yes No If yes, which joints and how severe?_____

_____

c. Muscle pain or achiness Yes No If yes, which muscles and how severe?_____

_____

d. When you get up in the morning, do you feel stiff in your joints, back or neck? Yes No

If yes, circle the location above & how long is it until you are as good as you will be for the day?

_____Minutes or _____hours

e. What factors have provided relief of your pain?_____

f. What factors or activities cause (increase) your pain? _____

g. How much pain have you had in the Past Week? Mark below to indicate how severe the pain has been

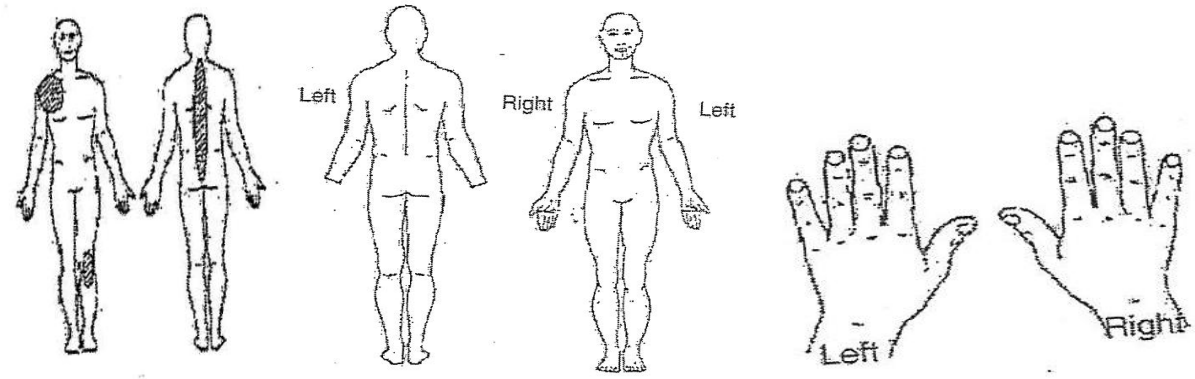
No pain 0--------1--------2---------3---------4---------5--------6---------7---------8---------9---------10 Severe

h. How much of a problem is UNUSUAL fatigue or tiredness for you over the Past Week?

None 0--------1--------2---------3---------4---------5--------6---------7---------8---------9---------10 Severe

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

Example:



Franciscan PHYSICIAN NETWORK

Past Medical History – Please check to the *left* if you have ever had any of these conditions

	Back pain		Irritable Bowel		Stroke		Diabetes
	Psoriasis		Migraine		Liver Disease		High Blood Pressure
	Ulcerative Colitis		Chronic pelvic pain		Hepatitis		High Cholesterol
	Crohn's Disease		Positive TB test		Lung Disease		Neuropathy
	Gluten Intolerance		Lyme Disease		COPD (emphysema)		Multiple Sclerosis
	Gout		Bleeding tendency		Asthma		Cancer
	Kidney Stones		Stomach Ulcers		Uveitis		Chemotherapy
	Kidney Disease		Heart Disease		Scleritis / episcleritis		Radiation Therapy
Others:							

Past Surgical History – Please check to the *left* if you have had any of these surgeries / date to right

X	Surgery	Date	X	Surgery	Date	X	Surgery	Date
	Knee Replaced			Back Surgery			Hysterectomy	
	Knee Scoped			Neck Surgery			Ovaries Removed	
	Hip Replaced			Carpal Tunnel			Tubal ligation	
	Shoulder replaced			Rotator Cuff			Vasectomy	
Others:								

Fractures/Injuries

Have you broken any bones in your adult life: Yes__ No __ If yes, was there significant trauma causing the fracture? Yes__ No__ Please list & explain _____

Social History

_____ Occupation:_____ Previous Occupation:_____ Retired __yes __No.
Are you receiving disability? __Yes __ No Are you applying for disability? __Yes __No
Tobacco use? __Yes __No __Past amount_____ Years_____ If quit, when?_____
Alcohol (beer, wine, liquor) __Yes __NO, If Yes, number of drinks per week _____
Travel: Where/when in last 2 years? _____
Exercise: Any exercise? __No __Yes __Walking __Aerobic Type __Other_____ _How often?_____

Family History – Has any blood relative had any of the following? If checked, what relationship?

X	Condition	Relation	X	Condition	Relation	X	Condition	Relation
	Rheumatoid arthritis			Ankylosing Spondylitis			Fibromyalgia	
	Lupus			Osteoporosis			Crohn's Disease	
	Gout			Broken Hip			Ulcerative colitis	
	Psoriatic arthritis			Osteoarthritis			Scleroderma	
Others arthritis or autoimmune disorder:								

Family Member	Health	Age if living or at death	Cause of Death		Family Member	Health	Age if living or at death	Cause of Death
Father					Brother			
Mother					Brother			
Daughter					Brother			
Daughter					Sister			
Son					Sister			
Son					Sister			

Franciscan
PHYSICIAN NETWORK

Drug allergy (List Name)	Reaction (or side effect)	Drug allergy (List Name)	Reaction (or side effect)
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Current Medications	Dose	Frequency	Duration	Current Medications	Dose	Frequency	Duration
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Past Medications (Complete if you have used any of these medications):	Dose	Duration (Dates)	Helped?	Reactions / Comments
1. tylenol (acetaminophen)				
2. motrin, advil (Iburprofen)				
3. naprosyn / aleve (naproxen)				
4. voltaren/Oruvail (diclofenac)				
5. mobic (meloxicam)				
6. sulidac (Clinoril)				
7. relafen (nabumatone)				
8. lodine (etodolac)				
9. tramadol (ultram, ultracet)				
10. vicodin, norco, lortab (hydrocodone)				
11. tylenol #3 or #4 (with codeine)				
12. oxycodone (percocet, oxycontin)				
13. cortisone/prednisone/steroids				
14. colchicine (colcrys)				
15. allopurinol (zyloprim)				
16. plaquenil (hydroxychloroquine)				
17. methotrexate				
18. sulfasalazine (azulfidine)				
19. arava (leflunomide)				
20. gabapentin (Neurontin)				
21. fosamax (alendronate)				
22. actonel (residronate)				
23. boniva (ibandronate)				
24. amitriptyline (elavil)				
25. nortriptyline (pamelor)				
26. desipramine (norpramin)				
27. flexeril (cyclobenzaprine)				
28. lyrica				
29. cymbalta				
30. savella				

Franciscan PHYSICIAN NETWORK

Systems Review: Please check Yes or No if you have recently had within 2 months the following:

General	Yes	No	Cardio-Respiratory	Yes	No
Tires Easily			Shortness of Breath		
Persistent Fever			Cough, persistent		
Weight Change			Bloody Sputum		
Change in Appetite			Swelling in legs		
Skin			Snoring / stop breathing during sleep		
Rash/Eruptions			Difficulty going to sleep		
Butterfly Rash			Excessive Daytime Sleepiness		
Finger and/or toes turn white or Blue in the cold			Morning Headaches		
			Non-refreshing Sleep		
Tight/Thickening of skin			Chest pain		
Changes in nails			Palpitations		
Unexplained hair loss			**Gastrointestinal**		
Nodules or lumps			Difficulty swallowing		
Sun sensitive			Nausea / Vomiting		
Eyes			Frequent heartburn		
Eye Pain			Abdominal pain / cramps		
Dry eyes daily			Diarrhea		
Inflamed eyes			Constipation		
Feels like something Is in eyes			Stomach Bleed		
Trouble seeing			Rectal Bleed		
Nose			**Nervous System**		
Sores			Headaches (New, often, or Severe)		
Bleeding			Weakness		
Mouth			Tingling Or numbness		
Mouth sores - Painless or Painful			Imbalance or falls		
Dry Mouth, often			Nightly muscle cramps		
Head/Neck			Dizziness or Fainting		
Sinus pain			Seizures		
Swollen glands			Anxiety/panic attacks		
Urology			Depression		
Blood in Urine			**Ears**		
Burning when Urinating			Loss of Hearing		
Genital Ulcers			Ringing in ears		
Genital Discharge			Change in voice/Hoarseness		

Females:
Date of last menstrual period_____ Have used hormones? Yes No
Pregnancies____ Deliveries____ Miscarriages____ Abortions____

Are there any cultural or religious beliefs that need to be considered in the care? __Yes __ No
If yes, _____

Signature_____ Relationship to patient_____ Date_____