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RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Please fill this questionnaire out as completely and accurately as you can. If this is possible for you, fax this back to us at your earliest convenience to 212-774-2284. It's better for us to get this sooner whenever possible. If you can't fax it, and there are at least 4 days before your appointment, then please mail it to us at the address at the beginning of this questionnaire. Whether you have faxed or mailed it, still please bring the original with you at the time of the visit, just in case we did not, for any reason, receive it. Feel free to call us after you fax it to make sure we have gotten it.

Please also complete the separate single page "Patient Registration" form.

In brief, what is the problem and when was the first symptom?

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Please list all of your medications, with dosages (including how many times a day you take it), including aspirin, Tylenol, ibuprofen (e.g., Advil), vitamins, etc:

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Please list all medications you have taken for pain or swelling in the past, and note any side – effects you recall from these drugs:

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Have you ever had:

physical therapy?	____yes	____no
acupuncture?	____yes	____no
used splints?	____yes	____no
Local steroid injection?	____yes	____no
psoriasis?	____yes	____no
colitis?	____yes	____no
eye inflammation?	____yes	____no
hypertension?	____yes	____no
diabetes?	____yes	____no
pneumonia?	____yes	____no
tuberculosis?	____yes	____no

Have you hade allergies to any medications? ____yes ____no
If yes, list details:

____
____
____

Have you had any operations or hospitalizations? ____yes ____no
If yes, list details:

____

Do you have any history of:

problem with aspirin?	____yes	____no
heart murmur?	____yes	____no
heart failure?	____yes	____no
heart attack?	____yes	____no
chest pain?	____yes	____no
ankle swelling?	____yes	____no

Do you have any history of:

ulcer?	____yes	____no
gastritis?	____yes	____no
heartburn?	____yes	____no
esophagitis?	____yes	____no
bleeding problem?	____yes	____no
polyps in the nose?	____yes	____no
asthma?	____yes	____no
hives?	____yes	____no
kidney problem?	____yes	____no
liver problem?	____yes	____no
glaucoma?	____yes	____no
cataract?	____yes	____no
phlebitis?	____yes	____no
shingles?	____yes	____no
low blood count?	____yes	____no
shortness of breath?	____yes	____no
emphysema?	____yes	____no

bronchitis?	____yes	____no
loss of vision?	____yes	____no
stroke?	____yes	____no
mini-stroke?	____yes	____no
passing out?	____yes	____no
depression?	____yes	____no
anesthesia problem?	____yes	____no
thyroid problem?	____yes	____no
night sweats?	____yes	____no
weight loss?	____yes	____no
thin bones?	____yes	____no

Do you have a family history of:

arthritis?	____yes	____no
diabetes?	____yes	____no
lupus?	____yes	____no
hypertension?	____yes	____no
heart problem?	____yes	____no
cancer?	____yes	____no

Does your Rheumatologic problem:

interfere with work?	____yes	____no
interfere with sleep?	____yes	____no
interfere with walking?	____yes	____no

Do you have any children? ____yes ____no

If yes, note the number of children, their names & ages, and any major illnesses they have had:

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Are you a smoker? ____yes ____no

If yes, how much? ____

____

Former smoker? If so, how much did you smoke and when did you stop?

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How much alcohol do you drink, on average?

____

What is your present weight? ______________

If you are a woman:

have you reached the menopause? ____yes ____no

are your menses irregular? ____yes ____no

have you had a miscarriage? ____yes ____no

If there is any other medical history which has not been covered above, or if you can provide any additional information regarding items noted above, please state:

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If there are any particular issues you would like covered during your visit, please state:

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PATIENT OR GUARDIAN'S SIGNATURE:________________________________Date:_________

Thank You