Piedmont HealthCare

Visit Date:_____

Name:_____ DOB:_____ M / F Referring MD:_____

What is the reason for your visit today:_____

How long has this been going on: _____

What other doctors have you seen for this problem: _____

Have you ever been told by a doctor you have any of the following conditions (Check all that apply):			
	Rheumatoid arthritis		Fibromyalgia
	Lupus		Tendonitis (where)
	Gout		Bursitis (where)
	Polymyalgia Rheumatica (PMR)		Osteoarthritis (where)
	Scleroderma		Osteoporosis
	Vasculitis		Degenerative disc disease
	Psoriatic arthritis		Spinal stenosis
	Ankylosing spondylitis		Radiculopathy (pinched nerve)
	Sjogren's syndrome		Myofascial pain

Have you ever taken any of the following medications (Check all that apply):			
	Prednisone (cortisone, steroids)		Allopurinol
	Steroid injections (cortisone shots)		Colchicine
	Naprosyn (Aleve)		Indomethacin (Indocin)
	Ibuprofen (Advil, Motrin)		Aspirin
	Vioxx		Tylenol (acetaminophen)
	Celebrex		Flexeril (cyclobenzaprine)
	Bextra		Amitriptyline (Elavil)
	Arthrotec		Trazadone
	Mobic		Ambien
	Salsalate		Ultram (Tramadol)
	Trilisate		Darvocet

Are you allergic to any medications? Please list medication and type of allergic reaction:

_____

_____

Patient Signature: _____ Date: _____

Piedmont HealthCare

Today's Date: _____

Name: _____ DOB:_____ M / F Referring MD:_____

Past Medical History:

Please list any chronic medical problems you have (diabetes, high blood pressure, stroke, etc):

_____ _____

_____ _____

_____ _____

_____ _____

Please list any surgeries:

_____ _____

_____ _____

_____ _____

Family History:

Do any of your family members (blood related) see a rheumatologist? _____

Please list diseases that run in your family: _____

_____

Social History:

Are you currently working: Y / N Occupation: _____

If not working, are you retired: Y / N On Disability: Y / N Applied for disability: Y / N

Have you ever smoked: Y / N Current: Y / N How much: _____ How long: _____

Have you ever consumed alcohol (beer, wine, liquor): Y / N Current: Y / N

How much alcohol do/did you drink in a week: _____

Have you ever used street drugs (marijuana, cocaine, heroin): Y / N

Do you have any tattoos: Y / N

Have you ever had a sexually transmitted disease (STD): Y / N

Have you ever been tested for Hepatitis B or C: Y / N Result: _____

Have you ever been tested for HIV/AIDS: Y / N Result: _____

Do you exercise regularly: Y / N How long each day: _____ Days/week: _____

Patient Signature: _____ Date: _____

Piedmont HealthCare

Today's Date:_____

Name:_____ DOB:_____ M / F Referring MD:_____

Review of systems:

Have you recently (last 6 months) experienced the following symptoms (check all that apply):			
	Fever persistently > 101		Prolonged blue or white color of fingers when cold
	Night sweats that make you change your clothes		Rash you put cream on or saw a doctor about
	Weight loss or weight gain **(Circle one)**		Psoriasis
	Poor sleep resulting in excessive daytime sleepiness		Hives
	Snoring		Abnormal hair loss
	Flu-like illness (fever, sore throat, aches, diarrhea etc)		Frequent headaches
	Pink eye (conjunctivitis)		Cramping pain in jaws with chewing
	Dry gritty eyes causing frequent need for eye drops		Loss of vision in one eye like shade being pulled
	Red, painful eyes, especially when looking in the light		Pain on sides of head when brushing or washing hair
	Sores in the mouth, especially the roof of the mouth		Muscle pains with household activity
	Dry mouth causing excessive thirst		Weakness (not fatigue)
	Recurrent sinus infections or ear infections		Numbness/tingling of arms/hands or legs/feet
	Palpitations		Depression or feeling down in the dumps
	Shortness of breath with activity		Anxiety or excessive worry
	Chest pain with deep breaths or cough (pleurisy)		Abnormal blood sugar - High or Low **(Circle one)**
	Stomach ulcer		Abnormal thyroid tests - High or Low **(Circle one)**
	GERD (reflux, heartburn)		Abnormal bleeding or bruising
	Black blood or red blood in stool **(Circle one)**		Low blood counts or anemia
	Frequent diarrhea or constipation		Joint pain involving hands/wrists or feet
	Crohn's or Ulcerative Colitis of the bowel **(Circle one)**		Widespread stiffness in the morning lasting > 1 hour
	Irritable bowel syndrome		Stiffness in low back in the morning lasting >1 hour
	Itching, burning, or increased frequency of urination		Joint swelling
	Vaginal or penile discharge		Acute attacks of arthritis lasting 2-3 days
	Vaginal or penile/scrotal ulcers		Joint pain worse in the morning than at night
	Urinary tract infection or blood in urine		Pain all over including muscles, joints, other areas

Patient Signature: _____ Date: _____