NAME:
DOB:

Susan Mathew, MD
Rheumatology

Please fax completed paperwork to 832-500-1399 or bring to office visit

Rheumatology -New Patient History

Who referred you? Please provide current contact information

Who is your PCP? Please provide full name, address, phone and fax

Describe briefly your present symptoms:

List all the Medical Problems Diagnosed Previously: (for example High blood pressure)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past Surgical History Date and Surgery please (use back if needed):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Drug Allergies: Yes / No, names: include reactions

Medications & Dosages (use back if needed):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Smoking: Yes / No, how much ____Cigs/packs ____years

Alcohol use: Yes / No, how much

Marital Status: *Circle one*

Never married / Married / Divorced / Separated / Widowed

Occupation:

Family History:

Indicate Status as A for Alive, D for deceased ***Please check appropriate boxes***

Members	Status (A)live (D)eceased	Diabetes	HTN	Heart Disease	Stroke	Mental Illness	Kidney Disease	Hypothyroidism	Autoimmune disease	High Cholesterol
Mother										
Father										
Siblings										
Children										
Paternal Grandmother										
Paternal Grandfather										
Maternal Grandmother										
Maternal Grandfather										
Cousins										

Rheumatological History: At any time have you or relative had any of the following? Check if yes

Yourself		*Relative Relationship*	*Yourself*		*Relative Relationship*
	Arthritis			*Lupus "SLE"*	
	Osteoarthritis			*Rheumatoid Arthritis*	
	Gout			*Ankylosing Spondylitis*	
	Child Arthritis			*Osteoporosis*	

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional
- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular
- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal
- ❑ Morning stiffness

  Lasting how long?

  _____Minutes _____Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric
- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic
- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____