# Arizona Arthritis & Rheumatology Associates, P.C.

| Today's Date: | | Patient Name: | | Birth Date: | |
|---|---|---|---|---|---|

**List of Consultants and Primary Care Doctor Information (Circle the referring doctor)**

| | | | | | |
|---|---|---|---|---|---|
| Primary Care Doctor Name: | | Phone: | | Fax: | |
| Consultant Name & Specialty: | | Phone: | | Fax: | |
| Consultant Name & Specialty: | | Phone: | | Fax: | |

**Chief Reason for Referral to Rheumatology (Main symptom, duration, location, treatments)**

**Past Medical History (Check formal diagnoses for which you may or may not take medications with approximate year of onset)**

| | | | |
|---|---|---|---|
| ☐ High Cholesterol year | ☐ Arrhythmia [ irregular heart beat] year | ☐ GERD/Acid Reflux year | ☐ Depression year |
| ☐ Hypertension/High BP year | ☐ Stroke year | ☐ Stomach ulcer year | ☐ Anxiety Disorder year |
| ☐ Type I Diabetes [Insulin] year | ☐ Specific bleeding disorder year | ☐ Fatty liver year | ☐ Insomnia year |
| ☐ Type II Diabetes year | ☐ Pulmonary Hypertension year | ☐ Hepatitis B year | ☐ Obstructive Sleep Apnea year |
| ☐ Thyroid Disease [type] year | ☐ Interstitial Lung Disease year | ☐ Hepatitis C year | ☐ ☐ Alcoholism or ☐ Drug Addiction year |
| ☐ Chronic Kidney Disease year | ☐ Pleural Effusion year | ☐ Celiac Sprue year | ☐ Coccidiomycosis [confirmed Valley Fever] year |
| ☐ Renal or Kidney Stones year | ☐ Pericardial Effusion year | ☐ Irritable Bowel Syndrome year | ☐ ☐ HIV ☐ TB ☐ STD ☐ Lyme Disease [check] year |
| ☐ ☐ Blood clots ☐ DVT ☐ PE [check] year | ☐ Asthma year | ☐ Seizure Disorder year | ☐ Major Trauma year |
| ☐ Coronary Artery Disease year | ☐ COPD or Emphysema year | ☐ Multiple Sclerosis year | ☐ XRT/Radiation Therapy year |
| ☐ Congestive Heart Failure year | ☐ Cancer [type] year | ☐ Migraine year | ☐ Others year |

**Past Medical History - Rheumatology Specific (Check formal diagnoses and give year of onset)**

| | | | |
|---|---|---|---|
| ☐ Osteoarthritis [location] year | ☐ Fracture spine, hip, other Site: year | ☐ Discoid Lupus year | ☐ ☐ Ulcerative Colitis or ☐ Crohn's disease [check] year |
| ☐ Degenerative discs in cervical spine year | ☐ Fibromyalgia year | ☐ Systemic Vasculitis [type] year | ☐ Ankylosing Spondylitis year |
| ☐ Degenerative discs in lumbar spine year | ☐ Gout year | ☐ Polymyalgia Rheumatica year | ☐ ☐ Iritis ☐ Uveitis ☐ Scleritis [check] year |
| ☐ Osteopenia year | ☐ Rheumatoid Arthritis year | ☐ Psoriasis year | ☐ ☐ Autoimmune liver ☐ autoimmune thyroid disease [check] year |
| ☐ Osteoporosis year | ☐ Systemic Lupus Erythematosus [SLE] year | ☐ Psoriatic Arthritis year | ☐ Others year |

**Past Surgical History (List past major surgeries, year of surgery, left/right side if applicable)**

| | | | | | |
|---|---|---|---|---|---|
| 1. | | 2. | | 3. | |
| 4. | | 5. | | 6. | |

**Allergies to drug, latex or others (List Allergies and Reactions)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | | 2. | | 3. | | 4. | |
| 5. | | 6. | | 7. | | 8. | |

**Current Medications (List prescription or over the counter medications you actively take)**

| | Name | Tablet Strength (Mgs, grams, etc.) | Frequency (once/day, twice/day, weekly, etc.) | Year it was started |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10 | | | | |

**Past Medications (Circle any past medications used that you do not take currently)**

| Medication | Year started and Year stopped | Benefit: Yes/No/Maybe | Major Side effects (if any) |
|---|---|---|---|
| Non Steroidal Anti-inflammatory [NSAIDS]:<br>☐ Ibuprofen ☐ Naproxen ☐ Diclofenac ☐ Relafen ☐ Indocin ☐ Clinoril<br>☐ Daypro ☐ Feldene ☐ Arthrotec ☐ Motrin ☐ Celebrex ☐ Lodine ☐ Meloxicam | | | |
| ☐ Tylenol [regular/XS/arthritis] ☐ Tramadol ☐ ASA | | | |
| ☐ Percocet ☐ Vicodin ☐ Oxycontin ☐ Other narcotics | | | |
| ☐ Gabapentin ☐ Lyrica ☐ Flexeril ☐ Robaxin ☐ Soma ☐ Cymbalta | | | |
| ☐ Colchicine ☐ Allopurinol ☐ Uloric ☐ Krystexxa | | | |
| ☐ Medrol ☐ Prednisone ☐ Rayos | | | |
| ☐ Synvisc ☐ Hyalgan ☐ Orthovisc ☐ Euflexxa injections | | | |
| ☐ Gold shots ☐ Plaquenil ☐ Methotrexate ☐ Arava | | | |
| ☐ Sulfasalazine ☐ Imuran ☐ Cellcept ☐ Cyclosporine | | | |
| ☐ Enbrel ☐ Humira ☐ Cimzia ☐ Simponi ☐ Remicade | | | |
| ☐ Orencia ☐ Actemra ☐ Xeljanz ☐ Otezla | | | |
| ☐ Rituxan ☐ Cytoxan ☐ Stelara ☐ Benlysta | | | |
| ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Reclast ☐ Prolia ☐ Forteo | | | |

**Family History (Check if family member has a CONFIRMED diagnosis and give relationship)**

| | | | |
|---|---|---|---|
| ☐ Osteoarthritis Who? | ☐ Psoriasis Who? | ☐ Polymyalgia Rheumatica Who? | ☐ Blood clots Who? |
| ☐ Osteoporosis Who? | ☐ Crohn's Disease Who? | ☐ Systemic Vasculitis Who? | ☐ Hypertension Who? |
| ☐ Gout Who? | ☐ Ulcerative Colitis Who? | ☐ Parent with Hip/Spine fracture Who? | ☐ Diabetes Who? |
| ☐ Rheumatoid Arthritis Who? | ☐ Ankylosing Spondylitis Who? | ☐ Cancer Who? | ☐ Heart Disease Who? |
| ☐ Systemic Lupus Who? | ☐ Iritis or Scleritis Who? | ☐ Tuberculosis Who? | ☐ Stroke Who? |

## Social History (Check or Circle if Applicable)

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | **Cigarette Smoking** | Never | | | 7. | **Birth Control measure, if any** |
| | | Current | # per day | Total years smoked: | 8. | **Currently Breastfeeding** Yes / No ☐ ☐ |
| | | Former | Quit date | Total years smoked: | 9. | **Last Menstrual: Period** **Age at Menopause:** |
| 2. | **Alcohol Use** | Yes / No ☐ ☐ | # Drinks/week: Beer/Wine/Spirit | | 10 | **Pregnancy** # Pregnancies # Miscarriages |
| 3. | **Drug Abuse (marijuana, illicit drugs, prescription narcotics)** | Yes / No ☐ ☐ | Type of Drug: | | 11 | **Last Eye Exam [date]:** **Mammogram: [year]** **Colonoscopy: [year]** **PAP smear: [year]** |
| 4. | **Exercise and type of exercise** | Yes / No ☐ ☐ | Duration and Frequency | | 12 | **Last Bone Density: [date]** **Last TB test & result [date]:** |
| | | | | | 13 | **Do you have a medically related lawsuit pending?** Yes / No ☐ ☐ Reason: |
| 5. | **Marital Status** | Single ☐ | Married ☐ | Domestic Partnership ☐ | 14 | **Are you on Disability or Applying for it?** Yes / No ☐ ☐ Reason: |
| 6. | **Trying to Conceive** | Yes / No ☐ ☐ | | | 15 | **Current Occupation** |

## Systems Review (SELECT RECENT OR ACTIVE symptoms associated with the REASON FOR REFERRAL)

| **GENERAL** | **NECK** | **GASTROINTESTINAL** | **MUSCULOSKELETAL** |
|---|---|---|---|
| ☐ Weight loss: [amount/time] | ☐ Hoarseness [excessive] | ☐ Nausea | ☐ Joint pain location |
| ☐ Weight gain: [amount/time] | ☐ Enlarged Node or large thyroid | ☐ Abdominal Pain | ☐ Joint swelling |
| ☐ Fatigue | **RESPIRATORY** | ☐ Vomiting | ☐ Morning stiffness duration |
| ☐ Fever | ☐ Cough [dry or productive] | ☐ Vomiting blood | ☐ Muscle Pain location |
| **SKIN** | ☐ Shortness of breath at rest | ☐ Blood in stools | ☐ Low back pain |
| ☐ Rash | ☐ Shortness of breath at exertion | ☐ Black stools | ☐ Neck pain |
| ☐ Raynaud's [color changes in hands/feet when cold] | ☐ Coughing of blood [hemoptysis] | ☐ Hemorrhoids | **NEUROLOGIC and PSYCHIATRIC** |
| ☐ Hair loss [patchy or thinning] | ☐ Wheezing | ☐ Heartburn [current] | ☐ Active Insomnia |
| **SPECIAL SENSES** | ☐ Snoring | ☐ Difficulty swallowing | ☐ Localized loss of muscle power |
| ☐ Hearing Loss | ☐ Sputum production [colored] | ☐ Diarrhea | ☐ Numbness: location |
| ☐ Dry Eyes | **BREAST** | **GENITOURINARY** | ☐ Tingling: location |
| ☐ Eye Pain with Eye Redness | ☐ Mass or Lump or Discharge | ☐ Blood in urine | ☐ Difficulty with speech |
| ☐ Double Vision | **CARDIOVASCULAR** | ☐ Painful urination | ☐ Active Anxiety |
| ☐ Vision Loss [blindness] | ☐ Chest Pain [new and active] | ☐ Flank pain | ☐ Active Depression |
| ☐ Dry mouth [excessive] | ☐ Leg Swelling [new or excessive] | ☐ Genital ulcer | **ENDOCRINE** |
| ☐ Oral Sores [recurrent] | ☐ History of Heart Murmur | ☐ Prostate trouble | ☐ Anorexia |
| ☐ Chronic Sinusitis | **HEMATOLOGIC** | ☐ Foamy urine | ☐ Cold intolerance [excessive] |
| ☐ Nosebleeds [frequent] | ☐ Abnormal bleeding or bruising | | |

**HEALTH QUESTIONNAIRE:**
**Please select and circle a number for each activity after reading about the task.**
**0 – no difficulty, 1 – some difficulty, 2 - much difficulty, 3 – unable to do**
**If you do not wish to fill this information, please indicate "Do not wish to fill".**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Dress yourself | 11. | Take a bath | Do you use these? | |
| 2. | Shampoo hair | 12. | Get on and off toilet | ☐ | Cane |
| 3. | Stand up from chair | 13. | Reach and get down a 5lb object from above your head | ☐ | Walker |
| 4. | Get in and out of bed | 14. | Bend down to pick up | ☐ | Crutches |
| 5. | Cut your meat | 15. | Open car doors | ☐ | Wheelchair |
| 6. | Lift a full cup or glass to your mouth | 16. | Open previously opened jars | ☐ | Built up chair |
| 7. | Open a new milk carton | 17. | Turn faucets on and off | ☐ | Built up utensils |
| 8. | Walk outdoors on flat ground | 18. | Run errands and shop | ☐ | Devices to dress |
| 9. | Climb up 5 steps | 19. | Get in and out of car | ☐ | Raised toilet seat |
| 10 | Wash and dry your body | 20. | Do chores (vacuum / yard work) | ☐ | Bathtub bar or seat |
| | | | | ☐ | Long-handled appliances for reach |

**VISUAL ANALOG PAIN SCALE**

Please report current pain intensity by drawing a perpendicular line on the horizontal line below.

**Worst imaginable pain 10** ---------- **0 No pain**

Office Use Only