Round Rock | South Austin | Central Austin | Cedar Park | Georgetown | Waco | Killeen | Amarillo

Phone: (512) 244-4272 | Fax: (512) 244-2895 | www.austinpaindoctor.com

Rheumatology New Patient Intake

Patient's Name: Date of Birth:

Date of Visit: Location of Care:

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

SOCIAL HISTORY

Chief Complaint (Reason for visit):____

Primary Care Provider? ____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widow/ Widower ☐ Separated ☐ Life Partner

Are you currently working? ☐ Yes | ☐ No If Yes: What is your occupation?______________________________

If No: Who took you off work?____

When did you stop working (if applicable)? ____

Any tobacco use? ☐ Yes | ☐ No Packs per day __________ for _____________ years

Any alcohol use? ☐ Yes | ☐ No Drinks per day __________ for _____________ years

Any recreational drug use? ☐ Yes | ☐ No Drugs used ____

Any special diet? ☐ Lactose free ☐ Caffeine Free ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other _____________

Past Surgical History

Type of Surgery	Details	Date and Hospital

Hospitalizations other than surgery (include date and facility name):____

____

Past Imaging History

Type of Imaging	Body Part	Facility Name

Medication History

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Do you have any medication/ drug allergies? Please list:____

____

Past Medical History

- ☐ Acid Reflux / GERD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bowel Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (Blood Clots in the legs)
- ☐ Emphysema
- ☐ Headaches / Migraines
- ☐ Heart Attack, Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Miscarriage
- ☐ PE (Blood Clots in the Lungs)
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Seizure
- ☐ Sinusitis
- ☐ Sleep Problems / Sleep Apnea
- ☐ Stomach Ulcers / Bleeding
- ☐ Stroke / Mini Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other

Rheumatolic History

- ☐ Antiphospholipid (APS)
- ☐ Avascular Necrosis
- ☐ Bursitis
- ☐ Dermatomyositis
- ☐ Fibromyalgia
- ☐ Fracture, Vertebral
- ☐ Fracture, Other
- ☐ Gout
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Periph Nerve-carpal tunnel
- ☐ Periph Never-tarsal tunnel
- ☐ Polymyalgia Rheumatica
- ☐ Polymyositis
- ☐ Pseudogout
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Sjogren’s Syndrome
- ☐ Tendonitis
- ☐ Vasculitis
- ☐ Other

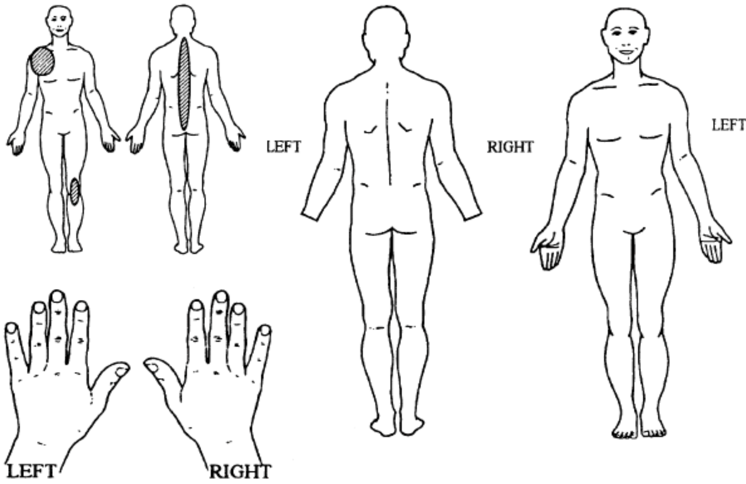
Family History

Has your Mother ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Has your Father ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Have any of your siblings ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Have any of your children ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Has your Mother's parents ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Has your Mother's siblings ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Has your Father's parents ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________
Has your Father's siblings ever had:	☐ Rheumatology	☐ Arthritis	☐ Other_______________

Any other family history and relation to you:____

Review of Systems

	Y	N		Y	N		Y	N
GENERAL			**GENITAL/URINARY TRACK**			**NERVOUS SYSTEM**		
Chills			Discharge			Bowel/bladder control		
Fatigue/tiredness			Painful urination			Headache		
Fevers			Frequency			Numbness/tingling		
Night sweats			Genital ulcer			Other		
Sleep disturbances			Blood in urine			**OB/GYN**		
Weight gain			Testicular pain			Abnormal menses		
Weight loss			Other			Menopause		
Other			**EYES/EARS/NOSE/THROAT**			Other		
ALLERGY			Diminished vision			**LUNGS**		
Seasonal			Eye pain			Cough		
Other			Dry eyes			Coughing blood		
HEART			Red eyes			Shortness of breath		
Chest pain			TMJ symptoms			Other		
Leg swelling			Dry mouth			**SKIN**		
Palpitation			Oral ulcers			Hair loss		
Other			Parotid gland swelling			Bruising		
HORMONE PROBLEMS			Imbalance			Sun-sensitive skin rash		
Thyroid			Hearing loss			Rash		
Other			Other			Raynaud's		
STOMACH/BOWEL			**BLOOD DISORDERS**			Skin ulcer		
Anorexia			Bleeding problems			Other		
Bloody/tarry stools			Blood transfusion history			**PSYCHIATRIC**		
Constipation			Other			Depression		
Diarrhea			**MUSCULOSKELETAL**			Anxiety		
Heartburn			Joint pain			Other		
Jaundice			Joint swelling			**NOTES:**		
Stomach upset			Muscle weakness					
Nausea			Morning stiffness > 1 hour (If "Y" ____ hrs: ____ mins)					
Vomiting			Muscle pain					
Other			Other					



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

PE:	N	A
GEN		
HEENT		
RESP		
CVS		
ABD		
MSK		
Gait		
Shoulder		
Elbow		
Wrist		
Hand		
Hips		
Knee		
Ankles		
Feet		
Spine		

Assessment:

Plan:

Patient Signature Employee's Initials Provider's Initials