3560 Delaware St. Ste 301 **Advanced Rheumatology Associates** p. 409-363-5675

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NEW PATIENT QUESTIONNAIRE

Patient Name:_____ Date:_____

What is the reason for your visit today?_____

Who is your Primary Care Physician?_____ Phone:_____

MEDICAL/PAST MEDICAL HISTORY: Have you ever had any of the following? Please check all that apply.

Osteoarthritis		Rheumatoid Arthritis		Lupus		Gout	
Fibromyalgia		Ankylosing Spondylitis		Psoriasis		Psoriatic Arthritis	
Sjogren's		Crohn's		Osteoporosis		Anemia	
Glaucoma		Migraine Headaches		Thyroid Disease		Neurological Disease	
Asthma		Hiatal Hernia		GERD		Cancer, Type:	
High Blood Pressure		Colon Polyps		Depression		Anxiety	
Heart Attack		Pneumonia		Diabetes, Type:		Coronary Artery Disease	
Rheumatic Fever		Diverticulitis		Hepatitis, Type:		Sickle Cell Anemia or Trait	
Emphysema		Kidney Stones		Stroke		Epilepsy	
Kidney Disease		Tuberculosis		Excessive Bleeding		Liver Disease	
Ulcers		Joint Pain		Muscle Pain		Bone Pain	

Any other pertinent past medical history you wish to include:

PAST SURGICAL HISTORY: Have you ever had any of the following? Please (CIRCLE) all that apply & indicate year.

	Year		Year		Year		Year
Gallbladder		Hysterectomy: Partial or Total		Coronary Bypass		Angioplasty	
Stent		Gastric Bypass/Lap Band		Miscarriages		Tubal Ligation	
Kidney		Arthroscopic, Type:		R-Knee Replacement		L-Knee Replacement	
R-Hip Replacement		L-Hip Replacement		Neck		Back	

Any other pertinent past surgical history you wish to include:

PRESENT MEDICATIONS: List all medications and doses, including over the counter medications/birth control/method._____
_____
_____
_____
_____

MEDICATION ALLERGIES: List any medication allergies you have and the kind of reaction for each.
_____

SOCIAL HISTORY: Do you drink alcohol?_____ If yes, estimate the number of drinks per week:____. Have you ever smoked?_____ Current?_____ How many packs per day?_____ How many years?_____. Have you ever used illegal drugs?_____ If yes, what kind was taken?_____. Do you exercise regularly?_____ How often and how long?_____. Occupation:_____.

FAMILY HISTORY: Did any Blood Relatives (parents, children, siblings) have any of the following? If yes, please state who.

Osteoarthritis	Rheumatoid Arthritis
Gout	Lupus
Fibromyalgia	Ankylosing Spondylitis
Psoriasis/Psoriatic Arthritis	Osteoporosis
Sjogren's	Crohn's