EAST ALABAMA
RHEUMATOLOGY CENTER
East Alabama Health

DR. LAURA B. HUGHES & DR. THAO N. TRAN

NAME: _____DOB:_____GENDER:_____
PRIMARY CARE PROVIDER/CLINIC:_____
PHARMARCY and PHONE:_____
ALLERGIES: _____

Reason why you are here to see the rheumatologist? Please briefly describe your symptoms.

When did your symptoms begin?

When you wake up in the morning, are your joints stiff? [ ] Yes or [ ] No; If Yes, for how many minutes?_____

Have you seen a rheumatologist in the past? If so, who? What diagnosis was this doctor treating you for?

Please list any previous treatment you have received for this problem?

**PAST MEDICAL HISTORY:** Have you had any of the following illnesses? (Check please)

| | | | | | |
|---|---|---|---|---|---|
| | Diabetes ("sugar") | | Heart Failure (CHF) | | Osteoarthritis |
| | High Blood Pressure | | Thyroid Problems | | Depression |
| | High Cholesterol | | Seizures | | Anxiety |
| | Asthma | | Headaches/Migraines | | Psoriasis |
| | COPD | | Kidney Disease | | Seasonal Allergies |
| | Stroke | | Kidney Stones | | Fibromyalgia |
| | Heart Attack | | Liver Problems | | Reflux (Heartburn) |
| | Obstructive Sleep Apnea | | Cancer | | Osteoporosis |

Please list any other medical conditions that you are being treated for?

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**MEDICATIONS:** Please list any medicines including supplements that you are currently taking (or bring a list with you). Please include strength and directions for taking.

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Please list medications you have tried in the past for your Autoimmune Condition. Please include reason for stopping, if any.

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**PAST SURGICAL HISTORIES:** Especially any relevant orthopedic procedures.

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**SOCIAL HISTORY:**

Smoking Status: [ ] Former Smoker [ ] Current Smoker [ ] Never Smoked

Do you drink alcohol? If so, how often? _____

Do you currently use/have ever used any illicit drugs? _____

Do you exercise? If yes, what do you do? How often? _____

How is your sleep at night? Please circle [ ] Good [ ] Fair [ ] Poor

Do you snore? [ ] Yes [ ] No

Are you: [ ] Married [ ] Single [ ] Divorced [ ] Separated

How many people reside in the home with you? Please list them.

What are your hobbies? How do you manage stress?

Employment type - Please circle: Full time Part time Retired Disabled

If Employed, what is your occupation?

**FAMILY HISTORY:** Please check where appropriate.

| **Diseases** | **Mother** | **Father** | **Siblings** | **Diseases** | **Mother** | **Father** | **Siblings** |
|---|---|---|---|---|---|---|---|
| Arthritis (type unknown) | | | | Gout | | | |
| Osteoarthritis | | | | Osteoporosis | | | |
| Rheumatoid Arthritis | | | | Ankylosing Spondylitis | | | |
| Systemic Lupus | | | | Crohn's | | | |
| Myositis | | | | Ulcerative Colitis | | | |
| Psoriasis | | | | Psoriatic Arthritis | | | |
| Gout | | | | Reactive Arthritis | | | |

Please list any other medical illnesses in your family:

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**REVIEW OF SYSTEMS** - Please circle any symptoms that pertain to you:

*Constitutional:* Fever / Chills / Fatigue / Weight change / Night Sweats / Insomnia / NONE

*Eyes:* Dry eyes / Visual Loss / Blurred Vision / Tearing / Redness / Pain / Glasses / Contacts / NONE

*ENT:* Dry Mouth / Mouth Sores / No Sores / Dental Pain / Cavities / None

*Cardio:* Racing heart / Chest pain / Chest Pressure / History of Pericarditis / NONE

*Pulm:* Shortness of Breath / Wheezing / Cough / Painful Breathing / NONE

*GI:* Nausea / Vomiting / Diarrhea / Heartburn / Blood in Stools / Difficulty or Painful Swallowing / NONE

*Skin:* Rashes / Dry Skin / Hair loss / Sun Sensitivity / Discoloration of hands with cold exposures / NONE

*Neuro:* Numbness / Tingling / Headaches / Weakness / Carpal Tunnel / Frequent Falls / NONE

**BONE HEALTH**

Have you ever had a bone density exam? [ ] Yes [ ] No. If yes, when was your last exam? _____

If you are a woman, have you gone through menopause? [ ] Yes [ ] No. If yes, when? _____

Do you take Calcium supplement? [ ] Yes [ ] No. If yes, how much? _____

Do you take Vitamin D Supplementation? [ ] Yes [ ] No. If yes, how much?_____

Have you ever had a fracture or broken bone? Please list: _____

Do you have a history of cancer or radiation? [ ] Yes [ ] No. If yes, when? _____

**VACCINATION**

Do you get your annual flu shot? [ ] Yes [ ] No. If not, why not? _____

Have you ever received the pneumonia vaccine? [ ] Yes [ ] No. If yes, when? _____

Have you ever received the zoster / shingles vaccine? [ ] Yes [ ] No. If yes, when? _____

Have you received any other vaccines as an adult? If so, please list_____

**WOMEN HEALTH**

Are you (circle): Post-menopause Pre-menopause Going through menopause

Please list last menstrual period (if pre-menopause)_____ Number of pregnancies_____

Number of live births _____Miscarriages_____Abortions_____

Are you planning to get pregnant? [ ] Yes [ ] No

If applicable, are you on birth control? [ ] Yes [ ] No. If yes, what type? _____

**Please indicate below if you have previously taken any of the medications below by marking the appropriate box and then why you stopped taking**

| Generic Name | Brand Name | Previously Used? | Reason for Stopping |
|---|---|---|---|
| Aspirin | Bayer Aspirin | | |
| Diclofenac (pills) | Arthrotec, Cambia, Zipsor | | |
| Diclofenac (topical) | Voltaren, Pennsaid, Flector | | |
| Etodolac | Lodine | | |
| Ibuprofen | Advil, Motril, Caldolor | | |
| Indomethacin | Indocin | | |
| Ketoprofen | Anafen | | |
| Ketorolac | Toradol | | |
| Meloxicam | Mobic | | |
| Nabumetone | Relafen | | |
| Naproxen | Aleve, Naprosyn | | |
| Piroxicam | Feldene | | |
| Sulindac | Clinoril | | |
| Azathioprine | Imuran | | |
| Methotrexate (pills) | Rheumatrex/Trexall | | |
| Methotrexate (injection) | Rasuvo/Otrexup | | |
| Hydroxychloroquine (HCQ) | Plaquenil | | |
| Mycophenolate | Cellcept | | |
| Sulfasalazine | Azulfidine | | |
| Leflunomide | Arava | | |
| Cyclosporin | Gengraf/Neoral/Sandimmune | | |
| Etanercept | Enbrel | | |
| Adalimumab | Humira | | |
| Infliximab | Remicade/Inflectra | | |
| Certolizumab | Cimiza | | |
| Golimumab | Simponi/Simponi Aria | | |
| Abatacept | Orencia | | |
| Rituximab | Rituxan | | |
| Tocilizumab | Actemra | | |
| Sarilumab | Kevzara | | |
| Tofacitinib | Xeljanz | | |
| Baricitinib | Olumiant | | |
| Upadacitinib | Rinvoq | | |
| Secukinumab | Cosentyx | | |
| Ixekizumab | Taltz | | |
| Ustekinumab | Stelara | | |
| Apremilast | Otezla | | |
| Anakinra | Kineret | | |
| Belimumab | Benlysta | | |

Patient Name: _____