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

NAME: ___________________________________DOB:_________________________GENDER:____________
PRIMARY CARE PROVIDER/CLINIC:____
PHARMACY 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)

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

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

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.

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

PAST SURGICAL HISTORIES: Especially any relevant orthopedic procedures.

Smoking Status (please mark 'X' next to your answer):

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 mark 'X' next to answer:

Good ___

Fair ___

Poor ___

Do you snore? ___Yes ___ No

Are you: Married, Single, Divorced, or 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 check.

Full time

Part time

Retired

Disabled

If employed, what is your occupation?

Smoking Status (please mark ‘X’ next to your answer):

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? __________________________________

____

____

____

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Do you snore? ___Yes ___ No

Are you: Married, Single, Divorced, or separated? ______

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

What are your hobbies? How do you manage stress?

FAMILY HISTORY: Please mark 'X' where appropriate.

Diseases	arthritis	gout	osteoarthritis	osteoporosis	Rheumatoid Arthritis	Ankylosing Spondylitis	Systemic Lupus	Crohn’s	Myositis
Mother									
Father									
Siblings									

CONTINUED:

Diseases	Ulcerative colitis	Psoriasis	Psoriatic Arthritis	Gout	Reactive Arthritis
mother					
father					
siblings					

Please list any other medical illnesses in your family:

REVIEW OF SYSTEMS - Please mar 'X' next to any symptoms that pertain to you:

Constitutional:
fever ___
chills ___
fatigue ___
night-sweats ___
weight change ___
insomnia ___
Eyes:
blurry vision ___
dry eyes ___
visual loss ___
tearing ___
redness ___
pain ___
glasses ___
contacts ___
Ears/Nose/Mouth/Throat:
Dry mouth ___
Mouth sores ___
decreased hearing ___
mouth sores ___
no sores ___
dental pain ___
Cardiovascular:
chest pain ___
chest pressure ___
history of pericarditis___
racing heart ___
Respiratory:
Cough ___
shortness of breath ___
wheezing ___
painful breathing ___
Gastrointestinal:
Nausea ___
Vomiting ___
Diarrhea ___
heartburn ___
difficulty or painful swallowing
blood in stool ___
Skin/Dermatologic:
Rashes ___
Dry skin ___
discoloration of hands with cold exposure ___
Neurologic:
Numbness ___
Tingling ___
Headaches ___
Weakness ___
carpal tunnel ___
frequent falls ___
Psychiatric:
Depression ___
Anxiety ___
difficulty sleeping ___
Hematologic:
Anemia ___
easy bruising ___

BONE HEALTH

Have you ever had a bone density exam? Yes, or no? ______ If yes, when was your last exam? __________

If you are a woman, have you gone through menopause? Yes, or no? _____ If yes, when? _______________

Do you take Calcium supplement? Yes, or no? _____ If yes, how much? _______________________________

Do you take Vitamin D Supplementation? Yes, or 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, or no? ______ If yes, when? ________________________________

VACCINATION

Do you get your annual flu shot? Yes, or no? _____ If not, why not? ___________________________________

Have you ever received the pneumonia vaccine? Yes, or no? _____ If yes, when? _______________________

Have you ever received the zoster / shingles vaccine? Yes, or no? _____ . If yes, when? _________________

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

____

WOMEN'S HEALTH

Are you 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 'X' in the previpusly used box your reason for stopping.

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: ____