BERGEN
GASTROENTEROLOGY • MEDICAL ASSOCIATES

committed to the highest level of patient care

RHEUMATOLOGY NEW PATIENT HISTORY FORM

First Name:____________________ **Last Name:**_____________________ **Date:**_____________ **MRN #:**____________________________

Age:___________ Birthdate:________________ Sex: __________

Marital Status: ◯Never married ◯Married ◯Divorced ◯Separated ◯Widowed ◯Partnered

Who said you needed a rheumatologist?______________________________

Name of your primary care physician:_______________________________

Describe briefly your present symptom(s):

When did your symptoms start?

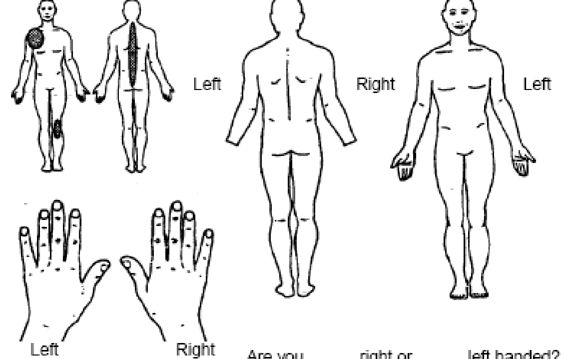
What diagnosis have you been given, if any?

Please list the practicioners & specialities you have seen for this:

What makes you better?

What makes you worse?

On a scale of 1 (no pain) to 10 (worst pain), how bad is your pain? _______



Previous treatment for this problem (include physical therapy, surgery, alternative treatments, and injections):

PAST MEDICAL HISTORY

Do you have now or did you have ever: check if "yes"

☐ Stomach or Peptic Ulcer	☐ Heart Problems	☐ Blood Clots	☐ Angina
☐ High Choltesterol	☐ Heart Murmur	☐ Pneumonia	☐ Glaucoma
☐ Hypothyroidism Goiter	☐ Emphysema	☐ Diabetes	☐ Cataracts
☐ High Blood Pressure	☐ Epilepsy	☐ Jaundice	☐ Rheumatic Fever
☐ Hepatitis or Liver Disease	☐ Stroke	☐ Hiv or Aids	☐ Kidney Disease
☐ Kidney or Bladder Stones	☐ Depression	☐ Anemia	☐ Asthma
☐ Pulmenary Embolism	☐ Anxiety	☐ Leukemia	☐ Tuberculosis
☐ Crohn's Disease or Colitis	☐ Psoriasis	☐ Lymphoma	☐ Cancer (Type) ____________

Other significant illnesses (please list):

Any previous fractures? ◯No ◯Yes Describe:_______________________________________

Any other serious injuries? ◯No ◯Yes Describe:_______________________________________

Physician Initials: ________________________________

Jeff Chung, M.D.

First Name:______________ Last Name:______________ Date:__________ MRN #:______________

RHEUMATOLOGIC (ARTHRITIS)

At any time have you or a blood relative had any of the following? (check if "yes")

	You	Relative	Relationship to you
Arthritis unknown type	☐	☐	
Osteoarthritis	☐	☐	
Rheumatoid arthritis	☐	☐	
Gout	☐	☐	
"SLE" or Lupus	☐	☐	
Ankylosing spondylitis	☐	☐	
Childhood arthritis	☐	☐	
Sjogren's syndrome	☐	☐	
Osteoporosis	☐	☐	
Psoriatic arthritis	☐	☐	
Fibromyalgia	☐	☐	

FAMILY HISTORY

	Age	Health Problems (if living)	Age at death (if deceased)	Cause(s) of
Father				
Mother				

Siblings

Children

PERSONAL HISTORY

What occupation(s) have you had?______________________________

If not working , are you: ◯ retired ◯ disabled ◯ on sick leave

When did this disability begin?______________________________

Do you receive disability or SSI? ◯ Yes ◯ No If yes, for what disability? ______________

What kind of exercise do you do? ______________ How often? ______________

Do you smoke? ◯ Yes ◯ No How much/often?______________

Do you drink alcohol? ◯ Yes ◯ No How much/often?______________

Usual drink:______________

Has anyone ever told you to cut down on your drinking?

◯ Yes ◯ No

Do you use drugs for reasons that are not medical?

◯ Yes ◯ No If yes, please list:______________

Do you get enough sleep at night? ◯ Yes ◯ No

Do you wake up feeling rested? ◯ Yes ◯ No

Physician Initials: ______________

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First Name: ____________ Last Name: ____________ Date: ________ MRN #: ________________

PREVIOUS SURGERIES/OPERATIONS

	Type	Year	Reason
1			
2			
3			
4			
5			

MEDICATIONS

What medication allergies do you have? What type of allergic reaction was it?

Please list below any prescribed and non-prescribed medicine that you are taking. Include vitamins, glucosamine,laxatives, calcium, etc.

SYSTEMS REVIEW

Date of last eye exam: ________ Date of last chest x-ray: ________ Date of last bone density test: ________

Result of last TB (PPD) test: ○ Never done ○ Negative ○ Positive Date test performed: ____________

General

- ☐ Recent weight gain: how much ________
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight loss: how much ________
- ☐ Weakness
- ☐ Night sweats

Muscle/Joints/Bones

- ☐ Morning stiffness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Lasting how long? (minutes/hours)
- ☐ Joint swelling

List joints affected in the last 6 months:

Ears

- ☐ Ringing in ears
- ☐ Loss of hearing

Eyes

- ☐ Pain
- ☐ Change or loss of vision
- ☐ Dryness
- ☐ Redness
- ☐ Double or blurred vision
- ☐ Feels like something in eye

Mouth

- ☐ Sore tongue
- ☐ Sores in mouth
- ☐ Dryness
- ☐ Bleeding gums
- ☐ Loss of taste
- ☐ Recent increase in tooth cavaties

Nose

- ☐ Nosebleeds
- ☐ Loss of smell

Throat

- ☐ Frequent sore throats
- ☐ Difficulty with swallowing
- ☐ Excessive thirst
- ☐ Hoarseness
- ☐ Jaw pain while chewing

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Neck

- [ ] Swollen glands
- [ ] Tender glands

Heart and Lungs

- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Pain in chest
- [ ] Wheezing
- [ ] Difficulty in breathing
- [ ] Irregular heart beat
- [ ] Cough
- [ ] Swollen legs or feet
- [ ] Sudden changes in heart

Stomach and Intestines

- [ ] Black stools
- [ ] Heartburn or gastritis
- [ ] Yellow jaundice
- [ ] Blood in stools
- [ ] Increasing constipation
- [ ] Nausea
- [ ] Vomitting of blood-"coffee grounds"
- [ ] Persistent diarrhea
- [ ] Stomach pain relieved by food or milk

Nervous system

- [ ] Severe or constant headaches
- [ ] Fainting/loss of consciousness
- [ ] Memory loss
- [ ] Dizziness
- [ ] Numbness/tingling of digits
- [ ] Muscle weakness

Psychiatric

- [ ] Sadness
- [ ] Difficulty falling asleep
- [ ] Excessive worries
- [ ] Difficulty staying asleep

Osteoporosis

- [ ] Getting shorter
- [ ] Frequent falls
- [ ] Low calcium intake
- [ ] Past cortisone intake
- [ ] Scoliosis

Blood/Immune

- [ ] Frequent infections of any type
- [ ] Bleeding tedency
- [ ] Blood transfusion

Skin

- [ ] Easy bruising
- [ ] Non-healing ulcers
- [ ] Hair loss
- [ ] Rash or hives
- [ ] Skin tightness
- [ ] Color changes of hands or feet in the cold (Raynaud's)
- [ ] Sun sensitive or sun allergy
- [ ] Nodules/bumps

Kidney/Urine Bladder

- [ ] Difficult urination
- [ ] Pus in urine
- [ ] Vaginal dryness
- [ ] Pain or burning on urination
- [ ] Blood in urine
- [ ] Rash/ulcers
- [ ] Frequent urination including night
- [ ] Cloudy, "smoky" urine
- [ ] Sexual difficulties
- [ ] Discharge from penis/vagina
- [ ] Prostate trouble

For women only:

Age when periods began: ____________

Number of pregnancies: ____________

Number of miscarriages: ____________

Have you reached menopause? ○ Yes ○ No If yes, at what age? ________

Have you had hormones? ○ Yes ○ No

Date of last Pap smear: ____________

Date of last mammogram: ____________

If you are still having periods:

Are they regular? ○ Yes ○ No How many days apart? ________

SAVE FORM SUBMIT FORM

Physician Initials: ____________

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