UCLA Health System

MRN:
Patient Name:

(Patient Label)

NEW PATIENT QUESTIONNAIRE

UCLA Department of Medicine
Rheumatology

Answering the following questions will help your doctor provide the best care for you. Please take the time to complete this survey before you see the doctor.

* Have you had arthritis or rheumatism for more than 3 months?..... ☐ No ☐ Yes

  Have you ever had joint stiffness in the morning lasting at least one hour for more than 6 weeks?..... ☐ No ☐ Yes

* Have you ever had nodules or bumps under the skin around the elbow or ankle? ☐ No ☐ Yes

* Have you ever had swelling in any of the following joints (lasting more than 6 weeks)?

	Left		Right	
a) wrist……	☐ No	☐ Yes	☐ No	☐ Yes
b) finger (but not the joints nearest the fingernails)	☐ No	☐ Yes	☐ No	☐ Yes
c) elbow……..	☐ No	☐ Yes	☐ No	☐ Yes
d) knee……	☐ No	☐ Yes	☐ No	☐ Yes

Review of Symptoms Checklist (check all the symptoms that apply to you)

General:

☐ Feeling ill
☐ Fatigued
☐ Fever
☐ Shaking Chills
☐ Back pain
☐ Drenching night sweats
☐ Decreased appetite
☐ Weight loss
(How many pounds _____?
Over how many months ____?

Head and Neck:

☐ Headaches
☐ Scalp pain
☐ Jaw pain with chewing or eating
☐ Rapid loss of lots of hair
☐ Multiple episodes of sinusitis
☐ Neck pain

Eyes:

☐ Gritty or sandy feeling in your eyes
☐ History of eye inflammation (redness or pain) requiring medical treatment
☐ Dry eyes

Skin:

☐ Rash on your cheeks for more than a month
☐ Psoriasis (scaly patches)
☐ Other types of rash (describe)
☐ Skin break out (rash) after being in the sun (not a sunburn)
☐ Puffy swollen fingers for more than a month
☐ Skin thickening or tightening of the fingers or toes
☐ Skin thickening or tightening of arms, legs, face, neck or trunk
☐ Sores leaving scars in the fingertips

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Review of Symptoms Checklist (check all the symptoms that apply to you)

Mouth:

- ☐ Sores in mouth or nose for more than 2 weeks at a time
- ☐ Dry mouth awakening you and requiring a drink of water
- ☐ Other dry mouth

Circulation:

- ☐ Fingers unusually sensitive to the cold
- ☐ Fingers change color in the cold

(circle all colors that apply)
White Blue Purple Red

- ☐ Blood clot in lungs, legs or other areas (please circle body part)

Chest Heart and lung Symptoms:

- ☐ Pleurisy or chest pain made worse by deep breathing for more than a few days
- ☐ Congestive Heart Failure
- ☐ Breathing difficulty with exercise
- ☐ Cough

With…	No	Yes
Sputum?	☐	☐
Blood?	☐	☐

- ☐ Angina
- ☐ Palpitations
- ☐ Asthma or wheezing

	No	Yes	
Do you know anyone with tuberculosis (TB) needs?	☐	☐	When? .
Have you ever had tuberculosis (TB)?	☐	☐	When?
Have you ever had tuberculosis (TB) skin test (PPD)?	☐	☐	Results Pos. ☐ Neg. ☐

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Ulcer
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in your stool

Infections:

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Frequent or recurrent infections
- ☐ HIV or AIDS

Travel History:

- ☐ US travel in last 5 years? (Where? _____)
- ☐ Out of country travel? (Where? _____)

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Review of Symptoms Checklist (check all the symptoms that apply to you)

Genito-urinary:
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Ulcers on vagina, penis, or scrotum
- ☐ Discharge from vagina or penis
- ☐ Sexually transmitted disease

(MALE ONLY)
- ☐ Prostate disease

Reproductive history:
- ☐ Infertility

(FEMALE ONLY)
- ☐ Miscarriages
- ☐ Menstrual cycle irregularities
- ☐ Menopause

Muscular:
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Muscle weakness for more than 3 months
- ☐ Weakness combing your hair for more than 3 months
- ☐ Weakness rising from a sitting position for more than 3 months

Neurologic:
- ☐ Stroke
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Seizure, convulsion or fit

Sleep problems:
- ☐ Sleep apnea
- ☐ Insomnia
- ☐ Daytime drowsiness

Psychiatric:
- ☐ Anxiety
- ☐ Depression

Endocrine:
- ☐ Adrenal disease
- ☐ Diabetes
- ☐ Heat or cold intolerance
- ☐ Thyroid disease

Hematologic:
- ☐ Easy bruising
- ☐ Lymphoma
- ☐ Swollen gland

Allergic/Immunologic:
- ☐ Hives

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ADDITIONAL MEDICAL QUESTIONS

*Have you had a blood test for rheumatoid arthritis? ……. ☐ No ☐ Yes

If YES, was the result ☐ negative? ☐ positive? ☐ don't know

*Have you had a blood test for lupus?
(e.g. antinuclear antibody, ANA, FANA or LE prep) …..……..... ☐ No ☐ Yes

If YES, was the result: ☐ negative? ☐ positive? ☐ don't know

*Have you ever been told by a doctor that you had:	No	Yes
Anemia? ……..…	☐	☐
Low white cell count? …….	☐	☐
Low platelet count? ……..	☐	☐
Protein in your urine? ……..…	☐	☐
Discoid lupus? ……..	☐	☐
Pulmonary fibrosis (scarring of the lungs) ……..….	☐	☐
High CPK (muscle enzyme)? …….....	☐	☐

SOCIAL HISTORY

*Regarding relationships, are you? (check one) ☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Widowed ☐ Other _____

*Have you had children? ☐ No ☐ Yes If Yes, how many? Son(s) ___ Daughter(s) ____

*Do you live? (check one) ☐ With Spouse/ Partner ☐ With family ☐ With friend(s) ☐ Alone

*Do you smoke? ☐ Never ☐ Currently ☐ Previously

*Started smoking at what age? _____ (OR) what year? _____

*Quit smoking at what age? _____ (OR) what year? _____

*Do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Less Frequently

*What do/did you drink? and # of drinks?
☐ Beer (# ____ per day or # per week ____)
☐ Wine (# ____ per day or # per week ____)
☐ Liquor (# ____ per day or # per week ____)

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OCCUPATIONAL HISTORY

*About your work, are you? ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled

*What is/was your main job? _____

*How many years in this job? _____

*When did you quit/retire (if applicable)? _____

*Was there a medical reason for quitting work? ☐ No ☐ Yes If Yes, specify: _____

FAMILY HISTORY (Please check all that apply)

	Father	Mother	Brother(s)	Sister(s)	Child	Aunt	Uncle
Rheumatoid Arthritis ……..	☐	☐	☐	☐	☐	☐	☐
Osteo–Arthritis (or) Degenerative Arthritis ……	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE) ……	☐	☐	☐	☐	☐	☐	☐
Osteoporosis ……..……	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis ……	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease …….	☐	☐	☐	☐	☐	☐	☐
Diabetes ……..	☐	☐	☐	☐	☐	☐	☐
Cardiovascular Disease ……	☐	☐	☐	☐	☐	☐	☐
Other Major Medical Problem ..	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

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NEW PATIENT QUESTIONNAIRE

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Health Assessment Questionnaire

Please check the response which best describes your usual abilities **(over the past week)**

At this moment are you able to:		Without any difficulty	With some difficulty	With much difficulty	Unable to do
Dressing/ Grooming	**Are you able to:**				
	1. Dress yourself, including tying shoelaces and doing buttons? ……	☐	☐	☐	☐
	2. Shampoo your hair ……..	☐	☐	☐	☐
Arising	**Are you able to:**				
	1. Stand up from an armless straight chair?	☐	☐	☐	☐
	2. Get in and out of bed? …….	☐	☐	☐	☐
Eating	**Are you able to:**				
	1. Cut your meat? ……..	☐	☐	☐	☐
	2. Lift a full cup or glass to your mouth? …	☐	☐	☐	☐
	3. Open a new carton of milk? …….	☐	☐	☐	☐
Walking	**Are you able to:**				
	1. Walk outdoors on flat ground? …….	☐	☐	☐	☐
	2. Climb up 5 steps? ……..	☐	☐	☐	☐
Hygiene	**Are you able to:**				
	1. Wash and dry your entire body? ……..	☐	☐	☐	☐
	2. Take a tub bath? …….	☐	☐	☐	☐
	3. Get on and off the toilet? ……...	☐	☐	☐	☐

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Health Assessment Questionnaire

At this moment are you able to:		Without any difficulty	With some difficulty	With much difficulty	Unable to do
Reach	**Are you able to:**				
	1. Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
	2. Bend down and pick up clothing from the floor?	☐	☐	☐	☐
Grip	**Are you able to:**				
	1. Open car doors?	☐	☐	☐	☐
	2. Open jars which have previously been opened?	☐	☐	☐	☐
	3. Turn regular taps on and off?	☐	☐	☐	☐
Activities	**Are you able to:**				
	1. Run errands and shop?	☐	☐	☐	☐
	2. Get in and out of a car?	☐	☐	☐	☐
	3. Do chores such as vacuuming or yardwork?	☐	☐	☐	☐

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Health Assessment Questionnaire

Please check any AIDS OR DEVICES that you usually use for any of these activities

- ☐ Raised Toilet Seat
- ☐ Bathtub Seat
- ☐ Jar Opener (for jars previously opened)
- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Other (Specify: _____)
- ☐ Bathtub Bar
- ☐ Long-handled appliances for reach
- ☐ Long-handled appliances in bathroom
- ☐ Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
- ☐ Built up or special utensils
- ☐ Special or built up chair

Please check any categories for which you usually need HELP FROM ANOTHER PERSON

- ☐ Dressing
- ☐ Arising
- ☐ Eating
- ☐ Walking
- ☐ Hygiene
- ☐ Reach
- ☐ Gripping
- ☐ Activities

MD initials _____