Bergen Medical Associates Jeff Chung, M.D.

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Rheumatology	New Patient His	tory Form	
Name:	Date:		MRN #:
Age:	Birthdate:		Sex:
Marital status: Never married Married Who said you needed a rheumatologist? Name of your primary care physician: Describe briefly your present symptom(s):	Divorced Separ	rated Uidowed Please shade all the loc the body figures and h Example:	Partnered ations of your pain over the past week on
When did your symptoms start?			ht Are you right or left handed? (Which hand do you sign your name with?)
What diagnosis have you been given, if any?			
Please list practitioners & specialties you have	seen for this		
What makes you better?			
What makes you worse?			
On a scale of 1 (no pain) to 10 (worst pain), ho	w bad is your pain?		
Previous treatment for this problem (include ph	nysical therapy, surgery,	alternative treatments,	and injections):

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Jeff Chung, M.D.

Any previous fractures? No Yes Describe: Any other serious injuries? No Yes Describe: RHEUMATOLOGIC (ARTHRITIS) * At any time have you or a blood relative had any of the following? (check if "yes") You Relative Relationship Arthritis unknown type Osteoarthritis Rheumatoid arthritis Rheumatoid arthritis Ankylosing spondylitis Ankylosing spondylitis Childhood arthritis Sjogren's syndrome Osteoporosis Sjogren's syndrome If living If deceased Age Health problems Age at death Cause(s) of Father Mother If living If deceased Age Age at death Age at death Cause(s) of Father			Date:		MRN #:		
■ kidney or bladder stones □ pulmonary embolism ■ high cholesterol □ ashma □ blood clots □ high cholesterol □ ashma □ plocumonia □ goiter □ epilepsy □ tuberculosis □ high blood pressure □ stroke □ diabetes □ heart problems □ depression □ jaundice □ heart murmar □ anxiety □ hiv or aids □ heart murmar □ axiety □ hiv or aids □ heart murmar □ axiety □ hiv or aids □ angina □ glaucoma □ ketkemia □ cancer (type) □ cataracts □ lymphoma Other significant illnesses (please list):		* Do you now have or did you ever					
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cancer (type)			-				
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Date:

MRN #:

Personal History

What occupation (s) have you had?						
what beeupation (3) have you had.						
If not working, are you:		retired		□ disabled	□ on sick leave	
When did this disability begin?						
Do you received 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?					Usual drink:	How much/often?
		Yes		□ No		
Has anyone ever told you to cut down on your drinkin	ng?		Yes		No	
Do you use drugs for reasons that are not medical?						If yes, please list:
			Yes		No	
Do you get enough sleep at night?						How many hours?
-			Yes		No	-
Do you wake up feeling rested?			Yes		No	

Previous Surgeries / Operations

Туре	Year	Reason
1		
2	- <u> </u>	
3		
4		
5	- <u> </u>	
6		
7	- <u> </u>	

Medications

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

Please list below any non-prescription agents that you are taking. Include vitamins, glucosamine, laxatives, calcium, etc.

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Physician Initials:

Jeff Chung, M.D.

Name:

Date:

MRN #:_____

Date of last eye exam ____

Result of last TB (PPD) test: INever done INegative Positive General Recent weight gain; how much____ □ Recent weight loss: how

Minutes

Hours

□ Fatigue

U Weakness

□ Fever

□ Night sweats

Muscle/Joints/Bones

□ Morning stiffness

Lasting how long? -

Joint pain

□ Joint swelling

Muscle weakness

List joints affected in the last 6 months

EARS

Ringing in ears

Loss of hearing

EYES

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

MOUTH

□ Sore tongue

Bleeding gums

□ Sores in mouth Loss of taste Dryness Recent increase in tooth cavities

NOSE

□ Nosebleeds Loss of smell

THROAT

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

Date of last chest x-ray ____

Systems Review

NECK Swollen glands □ Tender glands

HEART AND LUNGS

Coughing up blood □ Wheezing Cough □ Shortness of breath Difficulty in breathing at □ Swollen legs or feet Deain in chest □ Irregular heart beat Sudden changes in heart

STOMACH AND INTESTINES

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

NERVOUS SYSTEM

□ Severe or constant Dizziness □ Fainting or loss of □ Numbness or tingling in Memory loss □ Muscle weakness

PSYCHIATRIC

□ Sadness

Excessive worries

Difficulty falling asleep Difficulty staying asleep

OSTEOPOROSIS

- Getting shorter Past cortisone intake
- □ Frequent falls
- Scoliosis
- Low calcium intake

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Date of last bone density test ____

Date test performed:

BLOOD / IMMUNE □ Frequent infections of any type Bleeding tendency Blood transfusion

SKIN

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

KIDNEY/URINE/BLADDER

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

For women only:

Age when periods began: _____ Number of pregnancies: ____ Number of miscarriages: ____

Have you reached menopause?

□ No □ Yes

If yes, at what age: _ Have you had hormones?

□ No □ Yes

Date of last Pap smear: ____ Date of last mammogram: If you are still having periods: Are they regular? \Box Yes \Box No

How many days apart? _____

Physician Initials: