Bergen Medical Associates
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Rheumatology New Patient History Form

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):

_____

_____

_____

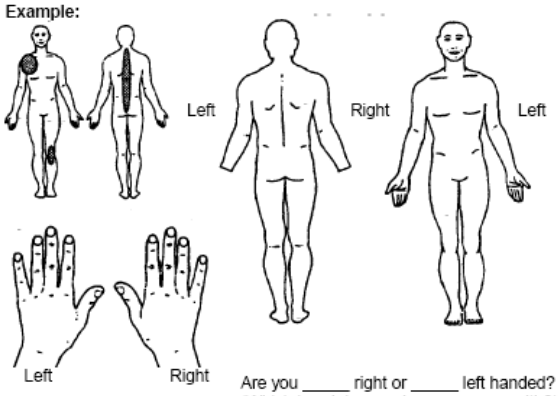
_____

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

_____

_____

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), how bad is your pain? _____

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

_____

_____

_____

_____

Physician Initials: _____
Jeff Chung, M.D.

Name: _____ **Date:** _____ **MRN #:** _____

Past Medical History

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

❑ Stomach or peptic ulcer	❑ hepatitis or liver disease	❑ crohn's disease or colitis
❑ kidney disease	❑ kidney or bladder stones	❑ pulmonary embolism
❑ high cholesterol	❑ asthma	❑ blood clots
❑ hypothyroidism	❑ emphysema	❑ pneumonia
❑ goiter	❑ epilepsy	❑ tuberculosis
❑ high blood pressure	❑ stroke	❑ diabetes
❑ heart problems	❑ depression	❑ jaundice
❑ heart murmur	❑ anxiety	❑ hiv or aids
❑ rheumatic fever	❑ psoriasis	❑ anemia
❑ angina	❑ glaucoma	❑ leukemia
❑ cancer (type) _____	❑ cataracts	❑ lymphoma

Other significant illnesses (please list): _____

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	❑	❑	→	
Gout	❑	❑	→	
"SLE" or Lupus	❑	❑	→	
Ankylosing spondylitis	❑	❑	→	
Childhood arthritis	❑	❑	→	
Sjogren's syndrome	❑	❑	→	
Osteoporosis	❑	❑	→	
Psoriatic arthritis	❑	❑	→	
Fibromyalgia	❑	❑	→	

FAMILY HISTORY

	If living		*If deceased*	
	Age	Health problems	Age at death	Cause(s) of
Father				
Mother				

Number of siblings: _____ Number living: _____

Number of children: _____ Number living: _____

List ages of each
Health of children and/or siblings: _____

Physician Initials: _____

Jeff Chung, M.D.

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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 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?	❑ Yes	❑ No	Usual drink:	How much/often?
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		How many hours?
Do you wake up feeling rested?	❑ Yes	❑ No		

Previous Surgeries / Operations

	Type	Year	Reason
1			
2			
3			
4			
5			
6			
7			

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.

Physician Initials: _____
Jeff Chung, M.D.

Name: _____ **Date:** _____ **MRN #:** _____

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_____
- ❑ Recent weight loss: how
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

Muscle/Joints/Bones
- ❑ Morning stiffness

Lasting how long? _____ Minutes _____ Hours
- ❑ 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

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Cough
- ❑ Shortness of breath
- ❑ Difficulty in breathing at
- ❑ Swollen legs or feet
- ❑ Pain 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

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
- ❑ Pus 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? ❑ Yes ❑ No

How many days apart? _____

Physician Initials: _____

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