

Arizona Arthritis & Rheumatology Associates, P.C.

Today's Date:	Patient Name:	Birth Date:
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List of Consultants and Primary Care Doctor Information (Circle the referring doctor)

Primary Care Doctor Name:	Phone:	Fax:
Consultant Name & Specialty:	Phone:	Fax:
Consultant Name & Specialty:	Phone:	Fax:

Chief Reason for Referral to Rheumatology (Main symptom, duration, location, treatments)

Past Medical History (Check formal diagnoses for which you may or may not take medications with approximate year of onset)

<input type="checkbox"/> High Cholesterol <u>year</u>	<input type="checkbox"/> Arrhythmia [irregular heart beat] <u>year</u>	<input type="checkbox"/> GERD/Acid Reflux <u>year</u>	<input type="checkbox"/> Depression <u>year</u>
<input type="checkbox"/> Hypertension/High BP <u>year</u>	<input type="checkbox"/> Stroke <u>year</u>	<input type="checkbox"/> Stomach ulcer <u>year</u>	<input type="checkbox"/> Anxiety Disorder <u>year</u>
<input type="checkbox"/> Type I Diabetes [Insulin] <u>year</u>	<input type="checkbox"/> Specific bleeding disorder <u>year</u>	<input type="checkbox"/> Fatty liver <u>year</u>	<input type="checkbox"/> Insomnia <u>year</u>
<input type="checkbox"/> Type II Diabetes <u>year</u>	<input type="checkbox"/> Pulmonary Hypertension <u>year</u>	<input type="checkbox"/> Hepatitis B <u>year</u>	<input type="checkbox"/> Obstructive Sleep Apnea <u>year</u>
<input type="checkbox"/> Thyroid Disease [type] <u>year</u>	<input type="checkbox"/> Interstitial Lung Disease <u>year</u>	<input type="checkbox"/> Hepatitis C <u>year</u>	<input type="checkbox"/> Alcoholism or Drug Addiction [circle] <u>year</u>
<input type="checkbox"/> Chronic Kidney Disease <u>year</u>	<input type="checkbox"/> Pleural Effusion <u>year</u>	<input type="checkbox"/> Celiac Sprue <u>year</u>	<input type="checkbox"/> Coccidiomycosis [confirmed Valley Fever] <u>year</u>
<input type="checkbox"/> Renal or Kidney Stones <u>year</u>	<input type="checkbox"/> Pericardial Effusion <u>year</u>	<input type="checkbox"/> Irritable Bowel Syndrome <u>year</u>	<input type="checkbox"/> HIV or TB or STD or Lyme Disease [circle] <u>year</u>
<input type="checkbox"/> Blood clots/DVT/PE [circle] <u>year</u>	<input type="checkbox"/> Asthma <u>year</u>	<input type="checkbox"/> Seizure Disorder <u>year</u>	<input type="checkbox"/> Major Trauma <u>year</u>
<input type="checkbox"/> Coronary Artery Disease <u>year</u>	<input type="checkbox"/> COPD or Emphysema <u>year</u>	<input type="checkbox"/> Multiple Sclerosis <u>year</u>	<input type="checkbox"/> XRT/Radiation Therapy <u>year</u>
<input type="checkbox"/> Congestive Heart Failure <u>year</u>	<input type="checkbox"/> Cancer [type] <u>year</u>	<input type="checkbox"/> Migraine <u>year</u>	<input type="checkbox"/> Others <u>year</u>

Past Medical History - Rheumatology Specific (Check formal diagnoses and give year of onset)

<input type="checkbox"/> Osteoarthritis [location] <u>year</u>	<input type="checkbox"/> Fracture spine, hip, other Site: <u>year</u>	<input type="checkbox"/> Discoid Lupus <u>year</u>	<input type="checkbox"/> Ulcerative Colitis or Crohn's disease [circle] <u>year</u>
<input type="checkbox"/> Degenerative discs in cervical spine <u>year</u>	<input type="checkbox"/> Fibromyalgia <u>year</u>	<input type="checkbox"/> Systemic Vasculitis [type] <u>year</u>	<input type="checkbox"/> Ankylosing Spondylitis <u>year</u>
<input type="checkbox"/> Degenerative discs in lumbar spine <u>year</u>	<input type="checkbox"/> Gout <u>year</u>	<input type="checkbox"/> Polymyalgia Rheumatica <u>year</u>	<input type="checkbox"/> Iritis or Uveitis or Scleritis [circle] <u>year</u>
<input type="checkbox"/> Osteopenia <u>year</u>	<input type="checkbox"/> Rheumatoid Arthritis <u>year</u>	<input type="checkbox"/> Psoriasis <u>year</u>	<input type="checkbox"/> Autoimmune liver or autoimmune thyroid disease [circle] <u>year</u>
<input type="checkbox"/> Osteoporosis <u>year</u>	<input type="checkbox"/> Systemic Lupus Erythematosus [SLE] <u>year</u>	<input type="checkbox"/> Psoriatic Arthritis <u>year</u>	<input type="checkbox"/> Others <u>year</u>

Past Surgical History (List past major surgeries, year of surgery, left/right side if applicable)

1.	2.	3.
4.	5.	6.

Allergies to drug, latex or others (List Allergies and Reactions)

1.	2.	3.	4.
5.	6.	7.	8.

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Current Medications (List prescription or over the counter medications you actively take)

#	Name	Tablet Strength (Mgs, grams, etc.)	Frequency (once/day, twice/day, weekly, etc.)	Year it was started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Past Medications (Circle any past medications used that you do not take currently)

Medication	Year started and Year stopped	Benefit: Yes/No/Maybe	Major Side effects (if any)
Non Steroidal Anti-inflammatory [NSAIDS]: Ibuprofen Naproxen Diclofenac Relafen Indocin Clinoril Daypro Feldene Arthrotec Motrin Celebrex Lodine Meloxicam			
Tylenol [regular/XS/arthritis] Tramadol ASA			
Percocet Vicodin Oxycontin Other narcotics			
Gabapentin Lyrica Flexeril Robaxin Soma Cymbalta			
Colchicine Allopurinol Uloric Krystexxa			
Medrol Prednisone Rayos			
Synvisc Hyalgan Orthovisc Euflexxa injections			
Gold shots Plaquenil Methotrexate Arava			
Sulfasalazine Imuran Cellcept Cyclosporine			
Enbrel Humira Cimzia Simponi Remicade			
Orencia Actemra Xeljanz Otezla			
Rituxan Cytosan Stelara Benlysta			
Fosamax Actonel Boniva Reclast Prolia Forteo			

Family History (Check if family member has a CONFIRMED diagnosis and give relationship)

<input type="checkbox"/> Osteoarthritis <u>Who?</u>	<input type="checkbox"/> Psoriasis <u>Who?</u>	<input type="checkbox"/> Polymyalgia Rheumatica <u>Who?</u>	<input type="checkbox"/> Blood clots <u>Who?</u>
<input type="checkbox"/> Osteoporosis <u>Who?</u>	<input type="checkbox"/> Crohn's Disease <u>Who?</u>	<input type="checkbox"/> Systemic Vasculitis <u>Who?</u>	<input type="checkbox"/> Hypertension <u>Who?</u>
<input type="checkbox"/> Gout <u>Who?</u>	<input type="checkbox"/> Ulcerative Colitis <u>Who?</u>	<input type="checkbox"/> Parent with Hip/Spine fracture <u>Who?</u>	<input type="checkbox"/> Diabetes <u>Who?</u>
<input type="checkbox"/> Rheumatoid Arthritis <u>Who?</u>	<input type="checkbox"/> Ankylosing Spondylitis <u>Who?</u>	<input type="checkbox"/> Cancer <u>Who?</u>	<input type="checkbox"/> Heart Disease <u>Who?</u>
<input type="checkbox"/> Systemic Lupus <u>Who?</u>	<input type="checkbox"/> Iritis or Scleritis <u>Who?</u>	<input type="checkbox"/> Tuberculosis <u>Who?</u>	<input type="checkbox"/> Stroke <u>Who?</u>

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Social History (Check or Circle if Applicable)								
1.	Cigarette Smoking	Never			7.	Birth Control measure, if any		
		Current	# per day	Total years smoked:		8.	Currently Breastfeeding Yes/ No	
		Former	Quit date	Total years smoked:			9.	Last Menstrual: Period
2.	Alcohol Use	Yes / No	# Drinks/week: Beer/Wine/Spirit		10	Pregnancy		# Pregnancies # Miscarriages
		3.	Drug Abuse (marijuana, illicit drugs, prescription narcotics)	Yes / No		Type of Drug:	11	Last Eye Exam [date]:
4.	Exercise and type of exercise	Yes / No	Duration and Frequency		12	Last Bone Density: [date]		Last TB test & result [date]:
		5.	Marital Status	Single		Married	Domestic Partnership	13
6.	Trying to Conceive			Yes / No		14	Are you on Disability or Applying for it?	
		15			Current Occupation			

Systems Review (SELECT RECENT OR ACTIVE symptoms associated with the REASON FOR REFERRAL)			
GENERAL	NECK	GASTROINTESTINAL	MUSCULOSKELETAL
<input type="checkbox"/> Weight loss: [amount/time]	<input type="checkbox"/> Hoarseness [excessive]	<input type="checkbox"/> Nausea	<input type="checkbox"/> Joint pain <u>location</u>
<input type="checkbox"/> Weight gain: [amount/time]	<input type="checkbox"/> Enlarged Node or large thyroid	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Fatigue	RESPIRATORY	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Morning stiffness <u>duration</u>
<input type="checkbox"/> Fever	<input type="checkbox"/> Cough [dry or productive]	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Muscle Pain <u>location</u>
SKIN	<input type="checkbox"/> Shortness of breath at rest	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Rash	<input type="checkbox"/> Shortness of breath at exertion	<input type="checkbox"/> Black stools	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Raynaud's [color changes in hands/feet when cold]	<input type="checkbox"/> Coughing of blood [hemoptysis]	<input type="checkbox"/> Hemorrhoids	NEUROLOGIC and PSYCHIATRIC
<input type="checkbox"/> Hair loss [patchy or thinning]	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Heartburn [current]	<input type="checkbox"/> Active Insomnia
SPECIAL SENSES	<input type="checkbox"/> Snoring	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Localized loss of muscle power
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sputum production [colored]	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Numbness: <u>location</u>
<input type="checkbox"/> Dry Eyes	BREAST	GENITOURINARY	<input type="checkbox"/> Tingling: <u>location</u>
<input type="checkbox"/> Eye Pain with Eye Redness	<input type="checkbox"/> Mass or Lump or Discharge	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Difficulty with speech
<input type="checkbox"/> Double Vision	CARDIOVASCULAR	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Active Anxiety
<input type="checkbox"/> Vision Loss [blindness]	<input type="checkbox"/> Chest Pain [new and active]	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Active Depression
<input type="checkbox"/> Dry mouth [excessive]	<input type="checkbox"/> Leg Swelling [new or excessive]	<input type="checkbox"/> Genital ulcer	ENDOCRINE
<input type="checkbox"/> Oral Sores [recurrent]	<input type="checkbox"/> History of Heart Murmur	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Chronic Sinusitis	HEMATOLOGIC	<input type="checkbox"/> Foamy urine	<input type="checkbox"/> Cold intolerance [excessive]
<input type="checkbox"/> Nosebleeds [frequent]	<input type="checkbox"/> Abnormal bleeding or bruising		

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HEALTH QUESTIONNAIRE:

Please select and circle a number for each activity after reading about the task.

0 – no difficulty, 1 – some difficulty, 2 - much difficulty, 3 – unable to do

If you do not wish to fill this information, please indicate "Do not wish to fill".

1.	Dress yourself	0 1 2 3	11.	Take a bath	0 1 2 3	Do you use these?	
2.	Shampoo hair	0 1 2 3	12.	Get on and off toilet	0 1 2 3	<input type="checkbox"/>	Cane
3.	Stand up from chair	0 1 2 3	13.	Reach and get down a 5lb object from above your head	0 1 2 3	<input type="checkbox"/>	Walker
4.	Get in and out of bed	0 1 2 3	14.	Bend down to pick up	0 1 2 3	<input type="checkbox"/>	Crutches
5.	Cut your meat	0 1 2 3	15.	Open car doors	0 1 2 3	<input type="checkbox"/>	Wheelchair
6.	Lift a full cup or glass to your mouth	0 1 2 3	16.	Open previously opened jars	0 1 2 3	<input type="checkbox"/>	Built up chair
7.	Open a new milk carton	0 1 2 3	17.	Turn faucets on and off	0 1 2 3	<input type="checkbox"/>	Built up utensils
8.	Walk outdoors on flat ground	0 1 2 3	18.	Run errands and shop	0 1 2 3	<input type="checkbox"/>	Devices to dress
9.	Climb up 5 steps	0 1 2 3	19.	Get in and out of car	0 1 2 3	<input type="checkbox"/>	Raised toilet seat
10.	Wash and dry your body	0 1 2 3	20.	Do chores (vacuum / yard work)	0 1 2 3	<input type="checkbox"/>	Bathtub bar or seat
						<input type="checkbox"/>	Long-handled appliances for reach

VISUAL ANALOG PAIN SCALE

Please report current pain intensity by drawing a perpendicular line on the horizontal line below.

Worst imaginable pain 10 ----- **0 No pain**

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