

# Rheumatology: Patient questionnaire

Please fill out this form and give it to the specialist you will be seeing today.

What is the most important problem we can help you with today? \_\_\_\_\_

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## Personal History

Please check the boxes below if you have had any of the following symptoms or conditions - either in the last 30 days or in the past. Check all that apply

<p><b>General</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety, nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent weight gain</p> <p><input type="checkbox"/> <input type="checkbox"/> Recent weight loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue (feeling tired or weak)</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol use problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p>	<p><b>Head, eyes, ears, nose, and throat</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Blindness</p> <p><input type="checkbox"/> <input type="checkbox"/> Dryness of mouth or eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Felt like something is in your eye</p> <p><input type="checkbox"/> <input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Trouble tasting</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus trouble</p>
<p><b>Nervous system</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Falls that cause injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> Carpal tunnel syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches or migraines</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p>	<p><b>Bladder and kidneys</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Burning during urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent night time urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Slow or weak stream</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stones</p>
<p><b>Heart and circulation</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath when lying flat</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in chest</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen legs, ankles, or feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood clot in the leg (phlebitis)</p>	<p><b>Stomach and intestines</b></p> <p>Past Present</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea, vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Trouble swallowing</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Black tarry stools</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritable bowel syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p>
<p><b>Lungs</b></p> <p>Past Present</p> <p>Shortness of breath after:</p> <p><input type="checkbox"/> <input type="checkbox"/> – walking 1 to 2 blocks</p> <p><input type="checkbox"/> <input type="checkbox"/> – after walking 1 flight of stairs</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma (wheezing)</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain on taking deep breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood clot in lung (pulmonary embolus)</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p>	

Skin		Blood	
Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Rash	<input type="checkbox"/>	<input type="checkbox"/> Bleeding problems
<input type="checkbox"/>	<input type="checkbox"/> Welts	<input type="checkbox"/>	<input type="checkbox"/> Anemia (low red blood cells)
<input type="checkbox"/>	<input type="checkbox"/> Itching		
<input type="checkbox"/>	<input type="checkbox"/> Rash over nose and cheeks		
<input type="checkbox"/>	<input type="checkbox"/> Patchy or total hair loss		
<input type="checkbox"/>	<input type="checkbox"/> Hands turn blue, white, or red in cold		
<input type="checkbox"/>	<input type="checkbox"/> Tight skin		
<input type="checkbox"/>	<input type="checkbox"/> Finger ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Psoriasis		
<input type="checkbox"/>	<input type="checkbox"/> Sick when in the sun		

**Habits and lifestyle**

Occupation (if you're retired, list your previous occupation): \_\_\_\_\_

How much of the following do you usually drink?

	Day	Week
Glasses of wine or bottles of beer _____ per	<input type="checkbox"/>	<input type="checkbox"/>
Ounces of hard liquor _____ per	<input type="checkbox"/>	<input type="checkbox"/>

If you used to drink alcoholic beverages but quit, give approximate date you stopped drinking: \_\_\_\_\_

List any regular physical exercise and activities you do and how often you do them:

Type of exercise or activity	Times per week
_____	_____
_____	_____