

Rheumatology Associates of North Jersey New Data Sheet

To our new patients: *Welcome* to our practice.

Personal History

SS: _____ - _____ - _____ Date: _____

Last Name: _____ First Name _____ Date of Birth ___/___/___ Age _____
 Address _____ City _____ State _____ Zip Code _____
 Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
 Email address _____
 Occupation _____ Employer _____
 Employer Address _____
 Medicare ID# _____ Secondary Insurance Company/ID# _____
 Insurance Company _____ ID# _____ Group# _____
 Primary Insured's Name _____
 Date of Last Examination _____
 Primary Doctor _____ Address _____ Phone # _____
 Referred by: _____ Pharmacy and Phone # _____
 Contact Name & Phone # of someone who can reach you _____

Authorization and Agreement

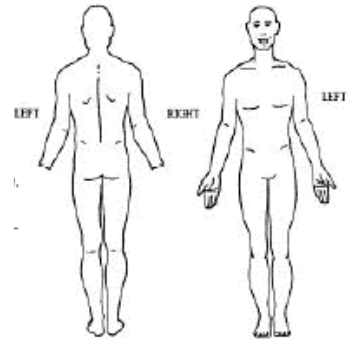
I authorize the release of any medical information necessary to process insurance claims. For federal benefits, I request payment either to myself or to the person who accepts assignment. I further agree to pay any legal or other fees entailed in the collection of any fees incurred through this office.

SIGN _____ **DATE** _____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

Please point to area(s) of difficulties:

1. _____
2. _____
3. _____



Previous treatment for this problem (physical therapy, surgery, injections, medications):

Who have you seen for this problem?

(Circle or fill in) **Main Problem**
Location: _____
What does it feel like?: Dull, Ache, Sharp, Shooting, Numb, Tingling, P&N, Burning other _____
How severe is it?: Mild Moderate Severe other _____
It began with: Nothing significant Trauma other _____
It lasts: Seconds / Minutes / Hours / It is continuous **It occurs:** Occasionally / daily / all day / at night
 / Once a week / Once a month
How long has this been happening?: days weeks months years
It is helped with _____ **It is worse with** _____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior Hospitalization, Surgery, and/or Trauma (list and dates)

Blood Transfusions (dates):

General Anesthesia:

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Children
Ankylosing Spondylitis						
Fibromyalgia						
Gout						
Lupus (SLE)						
Osteoarthritis						
Osteoporosis						
Psoriasis						
Rheumatoid Arthritis						
Other rheumatic disease (list)						

Please list previous treatments for above illnesses _____

Check if positive:

Yes

Yes

Yes

Alcoholism		Diabetes		Kidney Disease	
Alzheimer's		Emphysema		Liver Disease	
Anemia		Epilepsy		Mental Illness	
Anxiety		Glaucoma		Migraine/ Headaches	
Asthma		Heart Attack		Pneumonia	
Bleeding Disorder		Heart Trouble		Prostate Cancer	
Breast Cancer		Hepatitis (A/B/C)		Stroke	
Cancer (list)		High Blood Pressure		Thyroid Disease	
Cataract		Irritable Bowl Syndrome		Tuberculosis	
COPD		Inflammatory Bowl Disease		Ulcers	
Depression		(Crohn's/ Ulcerative colitis)			

Other illnesses _____

Current Medications:

Allergies: Penicilin _____ Sulfa _____ Asprin _____

Other Drug Allergies _____

SOCIAL HISTORY (check those that apply):**Marital status:**

- Single
 Married
 Divorced
 Widowed

Education level completed:

- high school
 college
 professional school
 other:

Birthplace: _____

Spouse's Name _____ No.Children _____

Living arrangement:

- Alone family roommate significant other
 Children (Name): _____

LIFESTYLE / SELF-CARE ISSUES

- Do you smoke cigarettes? YES NO If yes, how many? # _____ yrs. _____ packs per day
 Did you ever smoke? YES NO If yes, when did you quit? _____
 Do you drink alcohol? YES NO If yes, how much? Type _____ & _____ drinks per week
 Do you drink caffeinated beverages? YES NO If yes, which? _____
 Do you use recreational drugs? YES NO If yes, which? _____
 Do you exercise regularly? YES NO If no, why? _____

HEALTH SCREENING HISTORY

List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Colonoscopy _____

Blood tests _____

Immunizations: Pneumonia _____ Flu Shot _____ Shingles _____

Have you had a PPD placed recently (tuberculosis)? Yes No

Type of contraception _____ Number of Pregnancies _____

Osteoporosis Evaluation:

Personal/Family History

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Children
Osteoporosis						

Age at First Period (approx.) _____ Last Period _____ Were they regular? _____ How many days apart? _____

Do you take calcium supplementation? _____ Type and dose: _____

If no, why not? _____

How was your intake when you were young (circle)? Good Average Poor

Have you ever taken (circle): Fosamax Actonel Boniva Forteo Miacalcin Evista Estrogen Replacement Therapy

Last Bone Density Test: _____

Have you had a fracture since age 35? _____ What did you break? _____

How did it happen? _____

History of (circle)? Anorexia Bulimia Extended time without menstrual cycle Men: Impotence? _____

REVIEW OF SYSTEMS

Check any symptoms that currently apply to you:

<u>Constitutional</u>		<u>Cardiovascular</u>		<u>Skin</u>	
Poor appetite		Chest pain		Easy bruising	
Fevers		Fingers turn blue/white in cold		Dry skin	
Chills		Murmurs		Rash	
Weight loss		Palpitations		Hives	
Weight gain		Leg swelling		Sensitivity to sunlight	
Fatigue				Skin tightness	
Weakness				Hair loss	
Night sweats				Nodules	
<u>Eyes</u>					
Pain		<u>Lungs:</u>		<u>Neurological</u>	
Double or Blurry vision		Shortness of breath		Memory loss	
Loss of vision		Cough		Headache	
Dryness		Wheezing		Dizziness	
Itching				Burning pain	
<u>Ear, Nose, Mouth, Throat</u>					
Ulcers :		<u>Gastrointestinal</u>		<u>Psychiatric</u>	
Mouth		Nausea		Excessive worries	
Nose		Vomiting		Anxiety	
Nosebleeds		Stomach pain		Mood swings	
Trouble with taste/smell		Jaundice			
Dryness		Diarrhea			
Mouth		Bloody stool			
Nose		Heartburn			
<u>Genitourinary</u>					
Painful urination		<u>Musculoskeletal</u>		<u>Hematological</u>	
Blood in urine		Muscle weakness		Blood clot	
Penis/vagina discharge		Muscle tenderness		Swollen glands	
Vaginal dryness		Joint aching		Bleeding tendency	
Rash/ulcers		Joint swelling			
Prostate trouble		Morning stiffness:			
Pelvic pain		How long _____ minutes			
		Joint swelling:			
		Where?			

IF NOT NOTED IT IS NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

This history record has been designed to facilitate our patient's continuity of care at Rheumatology Associates. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

Date Patient/Guardian signature who filled out the history

Date Physician Signature