New Patient Form

Patient Name:_____ _Date:_____

Please take a moment to fill out the following forms front and back:

Pharmacy Information: (Include the Name, Address and Phone Number of the Pharmacy)

Preferred Local: _____

Preferred Mail Order/Specialty: _____

LIST ALL CURRENT MEDICATIONS BELOW INCLUDING INJECTIONS/INFUSION MEDICINES

Name of Medication	Dose	How often taken

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

*use an additional sheet of paper if necessary.

FILL OUT YOUR ALLERGIES BELOW- MUST COMPLETE AT EACH VISIT

Ingredient/Allergen	Type of allergic reaction
	❑rash ❑trouble breathing ❑stomach discomfort ❑other:
	❑rash ❑trouble breathing ❑stomach discomfort ❑other:
	❑rash ❑trouble breathing ❑stomach discomfort ❑other:
	❑rash ❑trouble breathing ❑stomach discomfort ❑other:

.

Review of Symptoms: Please mark the symptoms you have been having recently.
Check all boxes that apply

GENERAL
- ❑ fever
- ❑ chills
- ❑ fatigue
- ❑ weight loss
- ❑ insomnia

EYES
- ❑ vision loss
- ❑ dry eyes

EAR/NOSE/THROAT
- ❑ nasal drainage
- ❑ mouth sores

RESPIRATORY
- ❑ shortness of breath
- ❑ cough
- ❑ History of tuberculosis
- ❑ PPD positive

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations

VASCULAR
- ❑ leg swelling/edema
- ❑ Raynaud's

GASTROENTEROLOGY
- ❑ nausea
- ❑ heartburn
- ❑ vomiting
- ❑ diarrhea
- ❑ difficulty swallowing
- ❑ constipation
- ❑ blood in stool
- ❑ black tarry stool

UROLOGY
- ❑ painful urination
- ❑ blood in urine

ENDOCRINE
- ❑ heat intolerance
- ❑ cold intolerance
- ❑ hair loss

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ gait difficulties
- ❑ dizziness
- ❑ memory loss
- ❑ seizures

PSYCHOLOGY
- ❑ emotional problems
- ❑ difficulty concentrating

SKIN
- ❑ rash
- ❑ sun sensitivity

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ joint pain
- ❑ joint swelling
- ❑ muscle pain
- ❑ muscle weakness
- ❑ back pain
- ❑ neck stiffness

BLOOD/LYMPH
- ❑ swollen glands
- ❑ easy bruising

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HEALTH MAINTENANCE

Last Pneumonia Vaccine Date_____
❑Don't Know ❑Never had one ❑Declined

Have you had a Flu shot within the last year? □ No □ Yes Date_____
❑Don't Know ❑Declined

Last Bone Density (DEXA): Date_____
Results: ❑Normal ❑Osteopenia ❑Osteoporosis ❑Don't Know **OR** ❑Never had one ❑Declined

Last Chest X-ray Date_____Results: ❑Normal ❑Abnormal ❑Don't Know **OR** ❑Never had one □ Declined

Shingles Vaccine: ____ Yes Date:_____ ____ No _____ Declined

Tuberculosis test (PPD/Quantiferon Gold test): _____Yes Date:_____ _____ No

Medical History/Current Medical Problems (Check all that apply, fill in any others)

- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Polymyalgia Rheumatica (PMR)
- ❑ Osteoporosis
- ❑ Spinal Stenosis
- ❑ Rotator Tendonitis / Tear
- ❑ Bursitis
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Prostate Problems
- ❑ Bladder Problems _____
- ❑ Kidney disease
- ❑ Sjogren's Syndrome
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Celiac Disease
- □ Gout
- ❑ High Blood Pressure
- ❑ Diabetes Type 1 or Type 2
- ❑ Heart Disease:_____
- ❑ Heart Attack
- ❑ Atrial Fibrillation
- ❑ High cholesterol
- ❑ Emphysema / Asthma
- ❑ Reflux / GERD
- ❑ Stomach/GI problems:_____
- ❑ Depression
- ❑ Thyroid disorder
- ❑ Cancer, type_____
- ❑ Psoriasis
- ❑ Broken bone(s)? _____
- ❑ _____
- ❑ _____

Women's Health:

Currently pregnant? ❑Yes ❑No
Number of pregnancies_____ ❑ Number of miscarriages_____ □ Number of live births _____
Age at Menopause_____
Hysterectomy? ❑Yes ❑No

SURGERY HISTORY	Date	SURGERY HISTORY	Date
❑ angioplasty or stent		❑ lung surgery	
❑ open heart		❑prostate surgery	
❑ pacemaker		❑breast surgery	
❑ gastrointestinal		❑other	

Joint Surgery: Fill all boxes that apply. THIS IS SURGERY ONLY-NOT JOINT PAIN OR SYMPTOMS

❑ Hip Rt or Lt ❑ Knee Rt or Lt ❑Hand/Wrist Rt or Lt ❑Carpal tunnel Rt or Lt ❑Shoulder Rt or Lt
❑ Elbow Rt or Lt ❑ Foot/ankle Rt or Lt ❑ Neck ❑ Low back ❑Other Dates:

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On each row below, please read the diseases and then fill the boxes under any family members who have had it.

Family History Conditions/Problems	Father	Mother	Brother	Sister	Child
Diabetes	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑	❑	❑
Childhood arthritis	❑	❑	❑	❑	❑
Heart Problems	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Gout	❑	❑	❑	❑	❑
Psoriasis or psoriatic arthritis	❑	❑	❑	❑	❑
Lupus	❑	❑	❑	❑	❑
Osteoarthritis	❑	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑	❑
Thyroid disease	❑	❑	❑	❑	❑
Multiple Sclerosis	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

Social History/Habits

Race: □Hispanic □Non-Hispanic □Decline to report
Primary Language Spoken At Home □English □Other_____
Education: (circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School_____

Occupation: _____ ❑Retired
❑Disabled: Year of Disability_____ Reason for disability
_____

❑Married ❑Widowed ❑Divorced ❑Single ❑Significant Other

Children: ❑ Yes ❑No

Smoking: □ NO □ Yes _____ packs/day ❑Quit smoking in _____ ❑Never smoked

Alcohol use: □ No ❑Yes (drinks/week:_____)

Have you had any falls within the last year? ____No _____ Yes If yes, how many? _____

Exercise frequency: □ Never □ Occasional □ Daily □ 2-3 times/week □ 3-4 times/week
Type of exercise:
_____

Living Will: □ No □ Yes Healthcare Proxy □ No □ Yes Power of Attorney: □ No □ Yes

Name:_____Relationship:_____

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Patient Name:_____ _Date:_____

Referring Physician:_____PH:_____

Address:_____

Reason for visit: _____❑Joint pain ❑ Joint swelling

❑ Abnormal lab test ❑ Abnormal bone density ❑ Pain all over

Length of symptoms: ❑0-3 months ❑3-6 months ❑6-12 months ❑>1 year

Days of work missed last month due to arthritic condition: _____ (Leave blank if not employed or retired)

Over the last week, were you able to:	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
Dress yourself, including tying shoelaces and doing buttons?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of bed?	❑ 0	❑ 1	❑ 2	❑ 3
Lift a full cup or glass to your mouth?	❑ 0	❑ 1	❑ 2	❑ 3
Walk outdoors on flat ground?	❑ 0	❑ 1	❑ 2	❑ 3
Wash and dry your entire body?	❑ 0	❑ 1	❑ 2	❑ 3
Bend down and pick up clothing from the floor?	❑ 0	❑ 1	❑ 2	❑ 3
Turn regular faucets on and off?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of a car, bus, train or airplane?	❑ 0	❑ 1	❑ 2	❑ 3
Walk two miles if you wish?	❑ 0	❑ 1	❑ 2	❑ 3
Participate in recreational activities and sports as you would like, if you wish?	❑ 0	❑ 1	❑ 2	❑ 3

(for office use only: MDHAQ score_____)

1. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:
   NO PAIN PAIN AS BAD AS IT COULD BE

   0 1 2 3 4 5 6 7 8 9 10

   _____

2. How tired have you been OVER THE PAST WEEK? Please indicate how severe your fatigue has been:
   NO PROBLEM VERY TIRED

   0 1 2 3 4 5 6 7 8 9 10

   _____

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing.
   VERY WELL VERY POORLY

   0 1 2 3 4 5 6 7 8 9 10

   _____

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