Dear Future Patients,

Thank you for taking the time to complete this questionnaire prior to your first visit. While it may seem like a lengthy form, we have found it very helpful in ensuring that patients' initial visits run smoothly. It may also help you to remember symptoms or components of your history that you might otherwise have forgotten to bring up. You may complete this form online and print it out, or you can print and complete it on paper.

In addition, if you have had any testing done outside of Skylands Medical Group, please bring all reports, lab, results, and relevant notes to your first visit, or ask your doctor to fax them to us in advance.

We look forward to meeting you.

Sincerely,

Dr. Shari Flowers, MD FACR

Dr. Jason Liebowitz, MD FACR

Skylands Medical Group, P.A.
Rheumatology New Patient Questionnaire

Please fill out this form and bring to your first visit.

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Phone #: _____

Referred by: Self ☐ Doctor ☐ _____

Location/Phone#: _____

Name/address of Primary Care Doctor if different than above: Same as above: ☐

_____

Briefly describe reason for visit and present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____

Previous diagnosis for these symptoms (if any): _____

_____

Have you ever had a steroid/cortisone joint injection? Yes ☐ No ☐

If yes, when, and which joint? _____

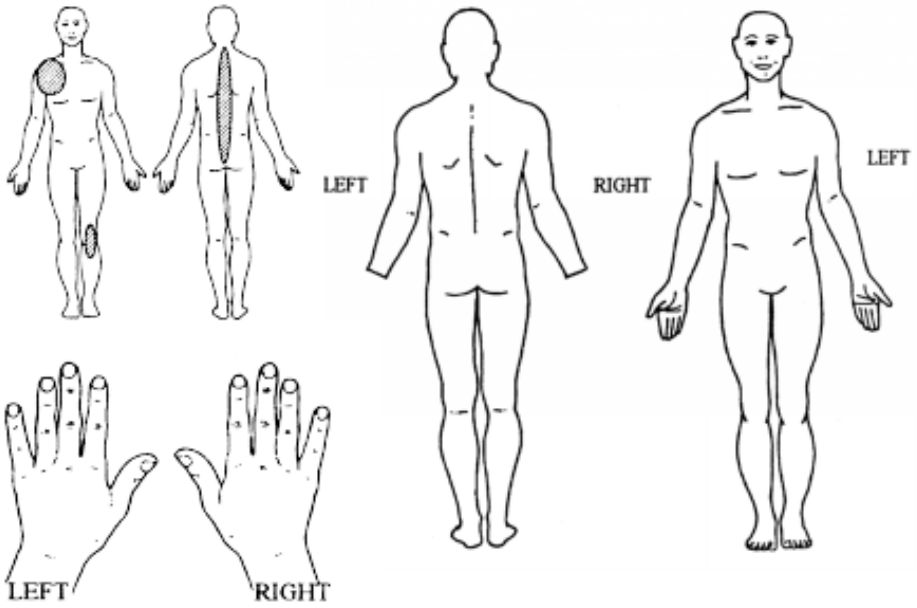
_____

Have you ever had hyaluronic acid/"gel" injections in a joint? (ex. Synvisc, Euflexxa, Orthovisc) _____

Have you ever had Physical Therapy for your condition? _____

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

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Past Medical History:

Do you now (or have you ever had):

- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Hyperthyroidism/Grave's
- ☐ Neuropathy
- ☐ Kidney Disease (not stones)
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Cancer, type & treatment:
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Heart disease, what type:
- ☐ High Cholesterol
- ☐ Emphysema/COPD
- ☐ Diabetes Type I__ Type II__
- ☐ Anemia
- ☐ Blood clot
- ☐ Iritis/Uveitis
- ☐ Stroke
- ☐ Colitis or Chron's
- ☐ Psoriasis
- ☐ Blood disorder
- ☐ Major infections

Rheumatic History:

Have you ever had (if so, when diagnosed):

- ☐ Lupus or "CTD" _____
- ☐ Vasculitis _____
- ☐ Rheumatoid Arthritis _____
- ☐ Psoriatic Arthritis _____
- ☐ Gout _____
- ☐ Pseudogout _____
- ☐ Scleroderma or Myositis _____
- ☐ Sjogren's Disease _____
- ☐ Ankylosing Spondylitis _____
- ☐ Osteoporosis _____
- ☐ Osteoarthritis _____
- ☐ Fibromyalgia _____

Other significant illness or details from above: _____

_____

Previous Operations (please list with approximate date): _____

_____

_____

Hospitalizations (please list with approximate date): _____

_____

Health Maintenance:

When was your last mammogram? _____ Was it normal or abnormal? _____

When was your last pap smear? _____ Was it normal or abnormal? _____

Last colonoscopy and results: _____

Last PSA (for men only)? _____

Last Bone Density and results: _____

Last **influenza** vaccination: _____ Last **pneumococcal** vaccination: _____

Last **PPD** (skin test for tuberculosis): _____ Positive ☐ Negative ☐

For Women Only: **Obstetrical /Gynecologic History:**

How many times have you been pregnant? _____ Full-term or pre-term? _____

Any complications during pregnancy? _____

How many miscarriages? _____ 1st, 2nd, or 3rd trimester? _____

How many abortions? _____

How old were you when your menstrual cycles ended? _____

All: To which **medications are you allergic**, and what reaction(s) do you have:

_____

_____

Current Medications:

(List any medications you are taking. Include over the counter products, laxatives, vitamins, supplements, herbs, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medicine?	Has it helped?			
			A lot	Some	Not at All	Don't Know
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Social History:

Married ☐ Partnered ☐ Single ☐ Divorced/Separated ☐ Widowed ☐

Any/how many children? _____ With whom do you live? _____

Tobacco (how much, for how long?): _____

Alcohol (how much?): _____

Occupation: _____

Family History:

Mother: How old is she now? _____ or At what age did she pass away? _____

What was the cause of death? _____

Past medical history: _____

Father: How old is he now? _____ or At what age did he pass away? _____

What was the cause of death? _____

Past medical history: _____

Brothers: please list ages and medical problems: _____

_____

Sisters: please list ages and medical problems: _____

_____

Who in your family has had a rheumatologic condition? (See above for list of the most common ones):

_____

Review of Systems:

Exercise: No ☐ Yes ☐ What type, how often: _____

Weight: How much have you gained or lost in the past year? _____

In the past 5 years? _____ Or has your weight remained stable? _____

Systems Review:

CHECK those that have significantly affected you recently:

Constitutional

- ☐ Unintentional Weight Loss
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Body Temperature >100.3

Eyes

- ☐ Pain
- ☐ Redness
- ☐ Recent change of vision
- ☐ Dryness
- ☐ Feels like something in the eye

Ear-Nose-Mouth-Throat

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Sores in nose
- ☐ Sores in mouth
- ☐ Dry mouth

Cardio-Vascular

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Pleurisy (persistent pain on breathing)
- ☐ Blood clots (DVT/PE)
- ☐ Color changes of hands or feet in the cold (Raynaud's)

Respiratory

- ☐ Shortness of breath
- ☐ Difficult breathing at night
- ☐ Coughing up blood
- ☐ Cough

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black stools
- ☐ Heartburn/Acid reflux

Genitourinary

- ☐ Blood in urine
- ☐ Pain on urination

Musculoskeletal

- ☐ Joint pain
- ☐ Muscle tenderness
- ☐ Tendonitis (where?) _____
- ☐ Heel Pain (Plantar Fasciitis)
- ☐ Posterior Ankle/Achille's Pain
- ☐ Morning Stiffness in Joints/Back

  Lasting how long?

  _____ Min _____ Hr

  Which joints?

  _____
- ☐ Individual finger/toe swelling
- ☐ Muscle weakness
- ☐ Joint swelling

  Which joints? _____
- ☐ Red joints
- ☐ Warm joints

Skin

- ☐ Rash (specify) _____
- ☐ Sores on finger tips
- ☐ Rash from the sun
- ☐ Hard or thickened skin
- ☐ Nodules
- ☐ Hair loss
- ☐ Feeling ill **after** sun exposure
- ☐ Nail putting/divots in nails
- ☐ Splitting/cracking nails
- ☐ Scaly skin:scalp, elbows, knees

Neurological

- ☐ Headache
- ☐ Muscle Spasm
- ☐ Tingling of limbs
- ☐ Numbness of limbs
- ☐ Memory loss

Psychiatric

- ☐ Excessive worry
- ☐ Anxiety
- ☐ Bipolar Disorder with Mania
- ☐ Bipolar Disorder w/o Mania
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Hematologic/Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Frequent Bruising
- ☐ Transfusion in past

  (when?) _____

In the past have you ever taken: (CHECK if yes)

Non-steroidal Anti-Inflammatory Drugs (NSAIDS):

- ☐ Advil/Motrin/Ibuprofen
- ☐ Celebrex
- ☐ Relafen (nabumetone)
- ☐ Aleve/Anaprox/Naproxen
- ☐ Mobic
- ☐ Voltaren (diclofenac)

Pain Relievers: _____

Gout Medicine:

- ☐ Colchicine
- ☐ Allopurinol (xyloprim)
- ☐ Probenacid (Benamid)
- ☐ Uloric (febuxastat)
- ☐ Kystexxa (pegloticase)
- ☐ Indocin (indomethacin)

Disease Modifying Antirheumatic Drugs (DMARDS):

- ☐ Methotrexate
- ☐ Consentyx
- ☐ Enbrel
- ☐ Remicade/Inflectra/Reflexis
- ☐ Simponi
- ☐ Cimzia
- ☐ Actemra
- ☐ Orenicia
- ☐ Cytoxan (cyclophosphamide)
- ☐ Imuran (azathioprine)
- ☐ Otezla
- ☐ Tacrolimus
- ☐ Taltz
- ☐ Rinvoq
- ☐ Saphenlo (anifromab)
- ☐ Plaquenil (Hydroxychloroquine)
- ☐ Sulfasalazine
- ☐ Arava (Leflunomide)
- ☐ Humira
- ☐ Kineret
- ☐ Olumiant
- ☐ Stelara
- ☐ CellCept (mycophenolate mofetil)
- ☐ Rituxan/Truxima (rituximab)
- ☐ Benlysta
- ☐ Lupkyni (voclosporin)
- ☐ Xeljanz

Other: _____

Muscle Relaxants:

- ☐ Flexeril (Cyclobenzaprine)
- ☐ Norflex (Orphenadrine)
- ☐ Norgesic Forte
- ☐ Zanaflex (Tizanidine)
- ☐ Skelaxin (Metaxalone)
- ☐ Robaxin (Methocarbamol)
- ☐ Soma (Carisoprodol)
- ☐ Valium (Diazepam)

Others:

- ☐ Prednisone/Medrol/Cortisone (Steroids)
- ☐ Elavil (Amitriptyline)
- ☐ Lyrica (pregablin)
- ☐ Pamelor (Nortriptyline)
- ☐ Neurontin (Gabapentin)
- ☐ Ultram/Ultracet/Tramadol

***** Please bring any pertinent lab reports, XRAY/MRI films and reports with you to your first visit. *****