the arva clinic

Rheumatology Clinic New Patient Form

NAME: _____

DOB: _____

DATE: _____

Age: _____ Marital Status (circle): Single Married Com-Law Widowed Separated Divorced

Number of Children: _____ Occupation: _____

Past Medical History

DO YOU HAVE OR HAVE YOU HAD ANY PROBLEMS RELATING TO YOUR ...?

☐ Eyes	☐ Throat	☐ Stomach	☐ Muscles
☐ Nose	☐ Heart	☐ Liver	☐ Bones
☐ Mouth/Jaw	☐ Chest	☐ Bowels	☐ Joints
☐ Ears	☐ Lungs	☐ Kidneys/Bladder	☐ Nerves
☐ Head/Brain	☐ Thyroid	☐ Pregnancy (miscarriage)	

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

☐ Heart Attack / Angina	☐ Thyroid Disease	☐ Osteoporosis	☐ Depression
☐ TIA / Stroke	☐ Hemochromatosis	☐ Hepatitis	☐ Tuberculosis
☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes	☐ Psoriasis

PLEASE LIST ANY OTHER MEDICAL PROBLEMS OR SURGERIES

ALLERGIES TO MEDICATIONS? ☐ NO ☐ YES - Please List: _____

SMOKING STATUS: ☐ Never ☐ Used to but quit ☐ Yes, Still do

ALCOHOL USE: ☐ Never ☐ Yes - Number of drinks per week: _____

DOES ANY OF YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING ...?

☐ Rheumatoid Arthritis	☐ Lupus	☐ Gout	☐ Psoriasis / Psoriatic Arthritis
☐ Crohn's / Ulcerative Colitis	☐ Blood Clots	☐ Cancer	☐ Raynaud's Phenomenon
☐ Osteoarthritis	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Ankylosing Spondylitis

PLEASE LIST ANY PRESCRIPTION MEDICATIONS YOU ARE TAKING:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

*** IMPORTANT *** Please Turn Over -->

HAQ-II (Health Assessment Questionnaire-II)

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities **OVER THE PAST WEEK**. *Are you able to:*

	Without any difficulty (0)	With some difficulty (1)	With much difficulty (2)	Unable (3)
Get on and off the toilet?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Go up 2 or more flights of stairs?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐

1. How much **PAIN** have you had because of your illness in the **PAST WEEK**?

No Pain ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ Very Severe Pain
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

2. How much of a **PROBLEM** has **FATIGUE or TIREDNESS** been for you **OVER THE PAST WEEK**?

Fatigue is no Problem ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ Fatigue is a Severe Problem
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

3. Considering **ALL THE WAYS** your **ARTHRITIS AFFECTS YOU**, **RATE HOW YOU ARE DOING** on the following scale.

Very Well ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ Very Poor
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

4. When you get up in the **MORNING** do you feel **STIFF**? ☐ YES ☐ NO

If you answer YES, please write the number of minutes: _____, OR number of hours:_____ until you are as limber as you will be for the day?

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Rheumatology Review of Systems

NAME: _____

DOB: _____

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO
Dry eyes where you need to put drops in your eyes on a daily basis?	☐	☐
A dry mouth making food difficult to swallow?	☐	☐
Frequent sores that come in your mouth?	☐	☐
Frequent sores that come in your nose?	☐	☐
Hair loss which is out of keeping with normal for you?	☐	☐
Swollen lymph nodes in your neck?	☐	☐
Chronic sinus problems with frequent infections or nosebleeds?	☐	☐
Pain in the chest when you take a deep breath in (pleurisy)?	☐	☐
Any rashes on your body?	☐	☐
Rashes that come when you are in the sun (not sunburn)?	☐	☐
Fingers that turn white in the cold (Raynaud's Phenomenon)?	☐	☐
Any miscarriages?	☐	☐
Any blood clots (deep venous thrombosis - DVT) in the legs?	☐	☐
Any blood clots in the lungs (pulmonary embolism)?	☐	☐
Any nodules on your body?	☐	☐
An eye condition called iritis where you had to put steroid drops in your eye?	☐	☐
A skin rash called psoriasis?	☐	☐
A first degree relative (mom, dad, brothers, or sisters) with psoriasis?	☐	☐
A diagnosis of inflammatory bowel disease - Crohn's disease or ulcerative colitis?	☐	☐
A first degree relative (mom, dad, brothers, or sisters) with Crohn's or ulcerative colitis?	☐	☐
A past diagnosis of Achilles tendonitis, plantar fasciitis, or costochondritis?	☐	☐
A finger or toe that has swollen up like a "sausage"	☐	☐
Any sexually transmitted infection such as chlamydia or gonorrhea?	☐	☐
A diarrheal or urinary tract infection that started 10-14 days before your arthritis?	☐	☐
Any documented fevers where you record your temperature using a thermometer?	☐	☐
Any weight loss which is unexplained?	☐	☐
Any other problems with your heart as far as you are aware?	☐	☐
Any other problems with your lungs as far as you are aware?	☐	☐
Any other problems with your liver as far as you are aware?	☐	☐
Any other problems with your kidneys as far as you are aware?	☐	☐
Any other problems with your bowels as far as you are aware?	☐	☐
Any other problems with your brain or nervous system as far as you are aware?	☐	☐

for office use only BP: Weigh (kg): Height (cm):