Central Florida Rheumatology Consultants, LLC

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New Patient Intake Form

Date of appointment: ____/____/_____

Name: _____ Birthdate:_____/_____/_____

Address: _____Age_____ Sex: ☐ F ☐ M

_____ Telephone: Home: (_____) _____

CITY STATE ZIP Mobile: (_____) _____

Email Address:_____

Birthplace: _____

Occupation (if retired, prior occupation): _____

Primary Insurance:_____ Member ID:_____ Group ID:_____

Secondary Insurance:_____ Member ID:_____ Group ID:_____

Marital status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other:_____

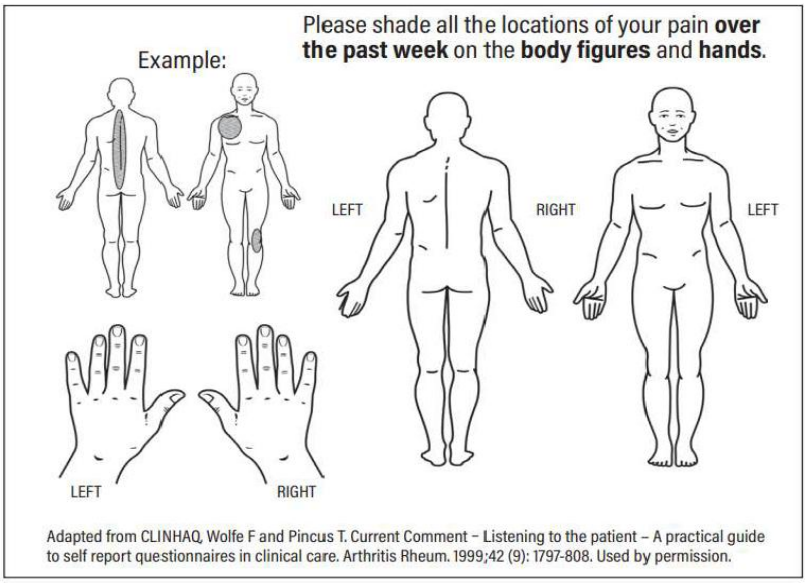
Primary Care Provider:_____

Name of person making referral:_____

Reason for referral to Rheumatology/Diagnosis:_____

_____

If applicable, please indicate areas of pain on the diagram below:



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.

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FAMILY HISTORY

At any time have you or a blood relative had any of the following? *(check if yes; list relationship)*

Condition		Relationship	Condition		Relationship
Psoriasis	❑		Lupus or "SLE"	❑	
Rheumatoid Arthritis	❑		Ankylosing Spondylitis	❑	
Childhood Arthritis	❑		Osteoarthritis	❑	
Gout	❑		Osteoporosis	❑	

SYSTEMS REVIEW

As you review the following list, please **check** any problems, which have significantly affected you:

Constitutional		**Gastrointestinal**		**Skin**	
❑	Recent weight gain	❑	Nausea	❑	Easy bruising
❑	Recent weight loss	❑	Vomiting	❑	Redness
❑	Fatigue	❑	Persistent diarrhea	❑	Rash
❑	Weakness	❑	Heartburn	❑	Sun sensitivity
❑	Fever	**Genitourinary**		❑	Hair loss
❑	Night sweats	❑	Blood in urine	❑	Color change of hands/feet
Eyes		**Musculoskeletal**		**Neurological System**	
❑	Pain	❑	Morning stiffness	❑	Headaches
❑	Redness	How long? ___mins____hrs		❑	Dizziness
❑	Dryness	❑	Joint pain	❑	Muscle spasm
Ear-Nose-Throat		❑	Muscle weakness	**Hematologic/Lymphatic**	
❑	Loss of hearing	❑	Muscle tenderness	❑	Swollen glands
❑	Nosebleeds	❑	Joint swelling	❑	Anemia
❑	Sores in mouth	**For Women Only**		❑	Bleeding tendency
❑	Dryness of mouth	❑	Number of pregnancies? _____		
❑	Difficulty swallowing	❑	Number of miscarriages? _____		
Respiratory					
❑	Shortness of breath				
❑	Cough				

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SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ Past- How long ago?____

Do you drink alcohol? Yes ☐ No ☐ Number per week___

Do you use drugs for reasons that are not medical?

☐ Yes ☐ No

If yes, please list:_____

Do you exercise regularly? ☐ Yes ☐ No

Type_____

Amount per week _____

MEDICAL HISTORY

Please check if you have or ever had:

☐ Cancer; type:_____year:_____

Treatment(s):_____

☐ Cataracts ☐ Epilepsy
☐ Diabetes ☐ Stroke
☐ Psoriasis ☐ Rheumatic fever
☐ Kidney disease ☐ Ulcerative Colitis
☐ Anemia ☐ Crohn's Disease
☐ Emphysema ☐ High blood pressure
☐ COPD ☐ Tuberculosis

☐ Heart disease; desc:_____
☐ Tuberculosis ☐ Hepatitis
☐ Stomach Ulcers ☐ Asthma

Have you been to the hospital recently?
If yes, when? _____
Other significant illness:
_____

Have you received Human Papillomavirus, Hep A, or Hep B vaccine? ❑ Yes ❑ No ❑ I don't know
If yes, what/when? _____
Have you ever been tested for HIV? ❑ Yes ❑ No ❑ I don't know
Have you ever been tested for Hepatitis C? ❑ Yes ❑ No ❑ I don't know
Have you been tested for tuberculosis in the past 2-years? ❑ Yes ❑ No ❑ I don't know
Are you at risk of contracting HIV or Hepatitis through blood exposures or sexual activities? ❑ Yes ❑ No ❑ Decline to answer
Would you like to receive free testing for HIV? ❑ Yes ❑ No ❑ Decline to answer
Would you like to be provided no cost counseling and preventative therapy (after consultation with a healthcare provider) for HIV? ❑ Yes ❑ No ❑ Decline to answer

**Note: Central Florida Rheumatology Consultants partners with Central Florida Health Care Services (CFHCS), a Florida non-profit healthcare organization who provides free HIV testing/screening, education/counseling (if elected) and treatment options/planning (if applicable). A representative from CFHCS will contact you if you elected yes to any request for no cost services above. Please note, all answers are confidential and protected as Personal Health Information (PHI).*

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		

Any previous fractures? ❑ Yes ❑ No
If yes, please describe (include time, treatment, etc.):_____

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FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				

MEDICATIONS

Drug Allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

CURRENT MEDICATIONS

(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	**Dose (include strength & number of pills per day)**	**How long have you taken this medication**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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PAST MEDICATIONS

Please review this list of Rheumatology medications. As accurately as possible, note the medications you have taken, how long you were on the medication, the results of taking the medication and list any reaction you may have had. If you have not been previously diagnosed with an autoimmune disorder, osteoporosis or gout you may skip Part 2-4.

Part 1: Over-the-counter and other pain relief

Drug names/ Dose	Length of time	Helped A lot	Helped Some	Did not help	Reactions, if any
Non- Steroidal Anti-Inflammatory Drugs (NSAID)		☐	☐	☐	

Circle any you have taken in the past (circle):

Diclofenac Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate

Flurbipofen Aspirin (including coated aspirin) Celebrex Sulindac

Oxaprozin Meloxicam Nabumetone Diclofenac +misoprostil Salsalate

Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Cholone magenesium trisalcylate

Part 2: Treatment for Autoimmune Diseases (SKIP IF NOT APPLICABLE)

Drug Name	IV, Injection, Both, or Oral	Did the medication help? (yes/no)	Why stopped?	Reactions, if any
Cimzia				
Simponi				
Hydroxychlorquine (plaquenil)				
Methotrexate				
Azazthioprine (Imuron)				
Sulfasalazine				
Cyclophosphamide				
Enbrel (etanercept)				
Infliximab (remicade)				
Actemra (tocilizumab)				
Taltz				
Cosentyx				
Otezla				
Mycophenolete				
Leflunomide (araua)				
Humira (adalimumab)				
Xeljanz (tofacitinab)				
Rituximab (rixutan)				

Orencia (abatacept)				
Rinvoq				
Olumiant				
Kevzara				
Saphnelo				
Benlysta (belimumab)				
Tremfya (guselkumab)				
Other:				
Part 3: Treatment for Osteoporosis (SKIP IF NOT APPLICABLE)				
Drug Name	**IV, Injection, Both, or Oral**	**Did the medication help? (yes/no)**	**Why stopped? Or "ongoing"**	**Reactions**
Estrogen				
Alendronate (fosomax)				
Raloxifene				
Calcitonin				
Risedronate				
Prolia (denosumab)				
Forteo				
Evenity				
Tymlos				
Part 4: Treatment for Gout (SKIP IF NOT APPLICABLE)				
Probenecid				
Colchicine				
Allopurnol				
Uloric				
Krystexxa				

Please list supplements:

_____

_____