Dignity Health Medical Group
Ventura County
A Service of Dignity Health Medical Foundation

RHEUMATOLOGY

Gita Fatemi, M.D.

Hello. Your Doctor has referred you to see me in regard to a musculoskeletal or immunologic problem. My specialty is Rheumatology which deals with the diagnosis and treatment of arthritis and related diseases. I would appreciate it if you fill out the following information. Skip any areas that do not apply. You may decline to answer if you wish. Note any questions and we will carefully go over them. Thank you,

–Gita Fatemi, M.D.

Name:_____Date:_____
Date of Birth:_____ Age:_____ Birthplace:_____ Sex: F / M Circle Right / Left handed
Referred here by: (check one) ___Self ___Family ___Friend ___Doctor ___Other Health Professional
Name of person making referral:_____
Name of the Physician providing your general medical care (PCP):_____
Have you seen a rheumatologist in the past?___yes ___no. If yes, Name(s)_____
Have you seen an orthopedic surgeon in the past?___yes ___no. If yes, Name(s)_____
_____

HISTORY OF CURRENT SYMPTOMS

Describe your current symptoms, how they developed and how they are now.

_____
_____
_____
_____
_____
_____
_____
_____

Date symptoms began (approximate)_____
Diagnosis Given? (Please List)_____
Previous Treatment for this problem (include physical therapy,surgery, injections, manipulation, massage, etc.
Medications to be listed later)_____
_____
_____
_____

Please list the names of other practitioners you have seen for this problem: _____
_____

Medications

Allergies or reactions to medicines or medical procedures: No _____ Yes _____
If Yes - Medicine or procedure | type of reaction | year
_____|_____|_____
_____|_____|_____
_____|_____|_____

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Prior Medications

Please list "arthritis" medications taken in the past, indicating how long you were taking it, the results of taking the medication and any reactions you may have had.

_____

_____

_____

_____

Have you taken Prednisone?_____

Have you taken long acting antirheumatic drugs (DMARDs)? (circle any or all that apply)
Gold, Hydroxychloroquine (Plaquenil), Methotrexate, Leflunomide (Arava), Azathioprine (Imuran), Sulfasalazine (Azulfidine), Etanercept (Enbrel), Infliximab (Remicade), Adalimumab (Humira), or Cyclophosphamide (Cytoxan)?_____

_____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative /relationship	Yourself		Relative /relationship
_____	Arthritis (type unknown)	_____	_____	Lupus or "SLE"	_____
_____	Osteoarthritis	_____	_____	Ankylosing Spondylitis	_____
_____	Rheumatoid Arthritis	_____	_____	Childhood Arthritis	_____
_____	Gout	_____	_____	Osteoporosis	_____

Other arthritic conditions_____

PAST MEDICAL HISTORY

Do you or have you had: (check if "yes")

Cancer_____	Heart Disease_____	Rheumatic Fever_____	Tuberculosis_____
Leukemia_____	High Blood Pressure_____	Epilepsy_____	Diabetes_____
Stroke_____	Bleeding Tendency_____	Asthma_____	Thyroid Disease_____
Colitis_____	Psoriasis_____	Anemia_____	Kidney Disease_____
Pneumonia_____	Stomach Ulcers_____	Cataracts_____	Jaundice_____

Other Significant Illnesses (please list including any hospitalizations) _____

_____

_____

Previous Operations (Even if mentioned previously)

	Year	Type of Surgery
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

Previous Fractures? No____ Yes____ Describe_____

Any other serious Injuries? No____ Yes____ Describe_____

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Rheumatology System Review

As you review the following list, **please** check any of these problems which apply to you.

GENERAL
_____Recent weight gain/loss
_____Fatigue
_____Weakness
_____Fever
_____Night sweats

EYES
_____Pain
_____Redness
_____Decreased vision
_____Double or blurred vision
_____Dryness
_____Feels like something in eye

EARS, NOSE, MOUTH & THROAT
_____Decreased hearing
_____Ringing in the ears
_____Nosebleeds
_____Loss of smell
_____Sinus problems or Allergies
_____Sores in the mouth
_____Bleeding gums
_____Loss of taste
_____Dry mouth
_____Bad teeth
_____Dentures
_____Frequent sore throats
_____Difficulty in swallowing

LUNGS
_____Shortness of breath
_____Cough
_____Coughing of blood
_____Wheezing
_____Pain in chest with breathing
_____Pneumonia or pleurisy
_____Tuberculosis or +TB skin test

HEART AND BLOOD VESSELS
_____Chest pain
_____Irregular heart beat
_____Difficulty breathing at night
_____Swollen legs or feet
_____Heart murmur
_____High blood pressure
_____Cramps in legs with walking
_____Blood clots or phlebitis

BLOOD
_____Swollen glands
_____Tender glands
_____Anemia
_____Bleeding tendency
_____Easy bruising

STOMACH AND INTESTINES
_____Nausea
_____Indigestion or heartburn
_____Vomiting up blood
_____Yellow jaundice or hepatitis
_____Constipation
_____Diarrhea
_____Blood in stools
_____Black stools
_____Abdominal pain
_____History of ulcers

KIDNEYS AND BLADDER
_____Burning with urination
_____Frequent urination
_____Blood in urine
_____Cloudy or "smokey" urine
_____History of kidney disease
_____Discharge form penis/vagina
_____Vaginal dryness (W)
_____Genital rash or ulcers
_____Sexual difficulties
_____Prostate trouble (M)

SKIN
_____Rash
_____Hives
_____Sun sensitive (sun allergy)
_____Tightness/Thickening
_____Nodules/bumps
_____Hair loss
_____Color changes in hands or feet in the cold

NERVOUS SYSTEM
_____Headaches
_____Dizziness
_____Weakness
_____Numbness or tingling
_____Tingling in the hands or feet
_____Memory loss
_____Loss of consciousness

PSYCHIATIRIC
_____Anxiety or excessive worries
_____Depression
_____Mood swings
_____Abnormal thoughts

SLEEP
_____Disturbed Sleep/Insomnia
_____Difficulty getting to sleep
_____Early awakening
_____Restless legs at night
_____Enough sleep at night
_____Still tired in the morning
_____Snoring
_____Sleep apnea

ENDOCRINE
_____Goiter/enlarged thyroid
_____Excessive thirst
_____Feel too hot or too cold

MUSCULOSKELSTAL
_____Joint Pain
_____Joint Swelling
_____Muscle Pain
_____Muscle Weakness
_____Morning Stiffness
Lasting How Long
_____Mins
_____Hrs
List joints affected in the last 6 mons
_____
_____
_____
_____

HABITS: Do you
Drink Coffee?_____Cups/day _____
Smoke? Yes ____No ____Past _____
Cigarettes per day? _____
Alcohol? Yes ____No ____Past_____
Has anyone ever told you to cut down on your drinking? Yes ___ No ___
Do you use drugs for reasons that are not medical? If so, please list.
_____
_____

MENSTRUAL HISTORY (Women)
Age when periods began_____
No. of Pregnancies?_____
No. of Live births?_____
No. of Miscarriages?_____

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_____

MARITAL STATUS

Never Married_____ Married (How many yrs.?)_____ Divorced_____ Separated_____
Spouse Alive (Age)_____ Deceased (Age)_____ Major Illnesses_____

EDUCATION (circle highest level attended):
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

OCCUPATION:_____ Number of hours worked/average per week____

Are you receiving disability?..... Yes _____ No _____
Are you applying for disability?..... Yes _____ No _____
Do you have a medically related lawsuit pending?..... Yes _____ No _____

ACTIVITIES OF DAILY LIVING

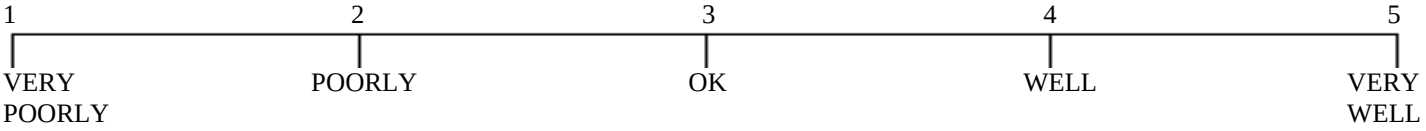
You live in (check one) ☐ House ☐ Apartment ☐ Other_____

Do you have stairs to climb? ☐Yes ☐No If yes, how many?_____

Number of people in household? _____ Relationship and age of each?_____

Who does most of the housework?_____ Most of the yard work?_____ Most of the shopping?_____

On the scale below, circle a number which best describes your situation; Most of the time, I function…



Other Concerns?_____

_____

_____

_____