

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____

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

PSYCHIATRIC

- 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

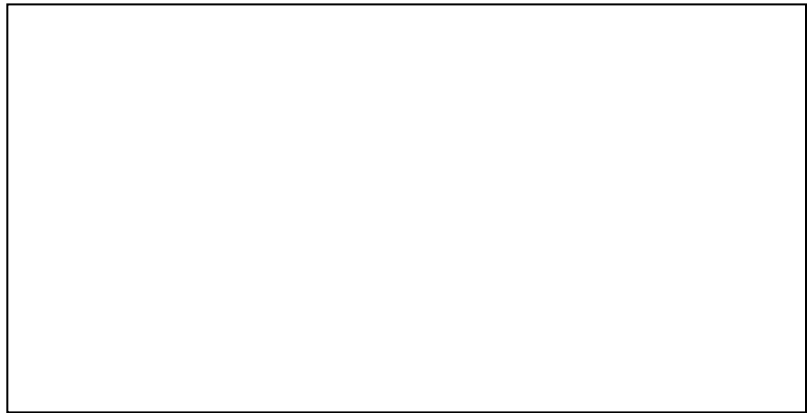
List joints affected in the last 6 mons

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? _____



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

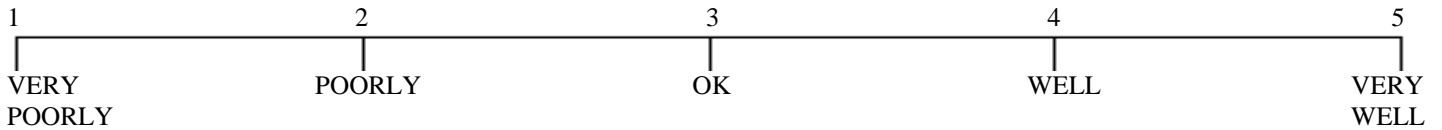
You live in (check one) House Apartment Other _____

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? _____

