Avera Medical Group Rheumatology
6100 S. Louise Ave.
Suite 1130
Sioux Falls, SD 57108
605-504-1600

Name: _____

Date of Birth: _____

Medical History

Rheumatology New Patient History Form

Please complete the form and bring it with you to your appointment.

Describe briefly your present symptoms: _____

Date that symptoms began: _____

Prior treatments for this problem (medications, injections, physical therapy, surgeries): _____

Name and location of primary care provider:

Please list any other providers that you have seen for this problem:

Do you have an orthopedic surgeon? If so, please list:

Past medical history

❑ Cancer
If yes, what type? _____
❑ Hepatitis
If yes, what type and when? _____
❑ Fractures after age 50
If yes, what bones? _____

❑ Diabetes mellitus	❑ Tuberculosis	❑ High cholesterol
❑ Depression or anxiety	❑ Sexually transmitted disease	❑ Heartburn
❑ Bad headaches		❑ Anemia
❑ Hypothyroidism	❑ Osteoporosis	❑ Asthma
❑ Pacemaker	❑ Glaucoma	❑ Kidney stones
❑ High blood pressure	❑ Seizures	❑ Kidney disease
❑ Stomach ulcers	❑ HIV	❑ Spinal disc problems
❑ Colitis	❑ Heart disease	
❑ Emphysema (COPD)	❑ Stroke	

For Women Only:

Having menstrual periods	❑ Yes	❑ No
Postmenopausal	❑ Yes	❑ No
Prior hysterectomy	❑ Yes	❑ No
Prior tubal ligation	❑ Yes	❑ No

Date of last period? _____
Number of pregnancies? _____
Number of miscarriages or abortions? _____
Use of any contraceptives? _____

Other medical problems or hospitalizations (please list)

Surgeries (if not mentioned elsewhere)

Type	Year	Reason

Social history

Current occupation (If not working now, what was your past occupation?

Work status
❑ working full time ❑ working part time
❑ homemaker ❑ seeking employment
❑ student ❑ retired ❑ disabled
❑ other (describe) _____

Marital status
❑ never married ❑ married ❑ divorced
❑ significant other ❑ widowed ❑ separated

Alcoholic beverage intake
❑ Yes ❑ No

Number of drinks per week _____

Tobacco use
❑ never
❑ in past but quit (amount per day and # of years)
❑ current use (Amount per day and # of years)

Any street drug use (past or present)?
If so, what kind? _____

How often per week and for how many minutes do you exercise aerobically (sweating, increased heart rate)?
Please describe: _____

Family history

Please mark if your parents, brothers, sisters or children have or have had any of the following, and explain:

❑ Rheumatoid arthritis _____
❑ Lupus _____
❑ Crohn's disease _____
❑ Ulcerative colitis _____
❑ Ankylosing spondylitis _____
❑ Psoriasis _____
❑ Multiple sclerosis _____
❑ Degenerative arthritis _____
❑ Joint replacements _____
❑ Fibromyalgia _____
❑ Gout _____
❑ Cancer _____
❑ Kidney disease _____
❑ Heartburn _____

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Rheumatology New Patient Review of Systems

Please check any of the following symptoms that apply to your current or prior health history.

Constitutional
- ❑ Fever
- ❑ Recent weight gain (Amount?) _____
- ❑ Recent weight loss (Amount?)_____
- ❑ Unusual fatigue
- ❑ Weakness

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat
- ❑ Dryness of mouth
- ❑ Sores in mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Runny nose
- ❑ Dryness in nose

Cardiovascular
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain
- ❑ Abnormal liver tests
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genital-Urinary
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties

Musculoskeletal
- ❑ Morning stiffness
  Lasting how long? _____Minutes _____Hours
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle weakness
- ❑ Muscle tenderness

List joints affected in the last 6 mos. (starting with most bothersome) _____
_____
_____
_____

Integumentary (skin)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold
- ❑ Tattoo(s)

Neurological
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Seizures
- ❑ Numbness or tingling of hands or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric—Sleep
- ❑ Depression
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Significant daytime sleepiness
- ❑ Significant snoring

Endocrine
- ❑ Excessive thirst
- ❑ Sexual problems

Hematologic—Lymphatic
- ❑ Swollen glands
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion

Date/location of last bone density test_____
Date of last eye exam _____
Date of last chest x-ray _____
Date of last colonoscopy _____