ACL Arthritis Center of Lexington

New Patient Questionnaire

Please complete all questions both front and back of this page

Patient Name: ________________________________ Age _____ Date of Birth ________________

Main reason for seeing the doctor: ________________________________

Medications or other treatments you have tried to date: ________________________________

The doctor who referred you here ____________________ Primary Care Doctor: ____________________

A copy of the Rheumatologist's report will go to your doctors, with your approval. Approve Yes ☐ No ☐

Medical History

Check all Illnesses or Conditions you have experienced now or in the past:

☐ Arthritis	☐ Hypertension	☐ Hepatitis	☐ Kidney Stones	☐ GERD or Reflux
☐ Gout	☐ COPD/Emphysema	☐ Seizures	☐ High Cholesterol	☐ HIV- AIDS
☐ Lupus	☐ Osteoporosis	☐ Asthma	☐ Migraine Headache	☐ Anemia
☐ Diabetes	☐ Osteopenia	☐ Stomach Ulcer	☐ Stroke	☐ Cancer
☐ Psoriasis	☐ Heart Attack or Stent	☐ Broken Bones (list)	____________________	☐ Leukemia
☐ Heart Failure	☐ Tuberculosis or +TB test			

Please Check all surgeries

☐ Gall Bladder	☐ Hip replacement
☐ Appendectomy	☐ Knee replacement
☐ Hysterectomy- partial	☐ Tubal Ligation
☐ Hysterectomy- complete	☐ Heart Bypass

List all other surgeries or medical illnesses

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Drug Allergies/Intolerances (type of reaction): ________________________________

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Women only: # of pregnancies: _____ # of births _____ # of miscarriages _____ How far along? ________

List all medicines you currently take, including dose and schedule: (You may also attach a list instead)

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Please list all significant or chronic illnesses within your close family. Please include illnesses such as arthritis, lupus, hypertension, cancer (and type), diabetes, heart, liver or lung disease, gout and osteoporosis:

Mother ________________________ Sisters/Brothers ________________________

Father ________________________ Children ________________________

Are you? ☐ Married ☐ Separated ☐ Divorced ☐ Single

Where do you live and who lives with you? ________________________________

Are you working now? ☐ No ☐ Part time ☐ Full Time ☐ Retired

Current or most recent job description ________________________________

Do you consider yourself disabled from doing any full time work? ________________________________

Please mark any of the following activities that are difficult for you: ☐ get dressed ☐ take a bath/shower ☐ drive a car ☐ walk a flight of stairs ☐ prepare food ☐ clean your house

Have you ever had drug or substance use problems or abuse? ☐ No ☐ Yes explain: ____________________

Do you drink alcohol? ☐ Not at all ☐ rarely, never heavy ☐ moderate ☐ more than 2 drinks daily

Do you smoke? ☐ never ☐ currently ☐ previously ____ packs/day for ____ years. Year quit: ____

(Please complete the other side of this page)

Please complete this page. Check the box next to each symptom that you have experienced significantly or frequently over the last two months.

General

- ☐ chills
- ☐ fevers
- ☐ general weakness
- ☐ unusual tiredness
- ☐ night sweats
- ☐ unintended weight loss
- ☐ unintended weight gain

Skin

- ☐ itching
- ☐ psoriasis
- ☐ welts, hives or nodules of the skin
- ☐ balding (loss of hair)
- ☐ rash following exposure to sun
- ☐ skin rash

HEENT

- ☐ blurred vision
- ☐ eye pain
- ☐ hearing loss
- ☐ ringing in the ears
- ☐ nose bleed
- ☐ nose sores
- ☐ sore throat
- ☐ pain in jaw or tongue with chewing food
- ☐ vision loss in one eye
- ☐ excessively dry eyes
- ☐ eye irritation or redness
- ☐ excessively dry mouth
- ☐ mouth sores or blisters

Respiratory

- ☐ cough
- ☐ coughing blood
- ☐ pain with coughing or deep breath
- ☐ wheezing
- ☐ producing phlegm or mucus
- ☐ severe snoring or sleep apnea
- ☐ shortness of breath

Circulatory

- ☐ chest pain
- ☐ feeling smothered while lying down
- ☐ passing out or fainting
- ☐ swelling in lower legs or feet
- ☐ palpitations/ rapid heart beat

Gastrointestinal

- ☐ constipation
- ☐ diarrhea
- ☐ frequent heartburn
- ☐ difficult or painful swallowing
- ☐ nausea or vomiting
- ☐ bloody or unusually dark bowel movements
- ☐ swelling of the abdomen (belly)
- ☐ abdominal (stomach) pain

Genitourinary

- ☐ blood in urine
- ☐ painful urination
- ☐ frequent urination
- ☐ difficulty controlling urine
- ☐ genital sores or discharge

Musculoskeletal

- ☐ joint swelling
- ☐ significant joint pain
- ☐ significant back or neck pain
- ☐ stiffness for more than one hour each a.m.
- ☐ cold and discolored hands/feet with exposure to cold or cool temperatures
- ☐ red or hot feeling joints

Neurologic

- ☐ tremor
- ☐ numbness or tingling in the hands
- ☐ numbness or tingling in the feet
- ☐ memory loss
- ☐ frequent or severe headaches
- ☐ loss of strength in muscles

Psychiatric

- ☐ hallucinations
- ☐ unusual sadness
- ☐ problems with sleep
- ☐ anxiousness

Endocrine

- ☐ excessive thirst
- ☐ intolerance to heat
- ☐ intolerance to cold

Hematologic

- ☐ easy bruising of the skin
- ☐ lumps or knots under the arms, neck or groin
- ☐ bleeding without cause

*Sign or initial here when both sides are complete*_______________________________________