MICHIGAN RHEUMATOLOGY
& WELLNESS CENTER, PLC

Today's Date:		Patient Name:		Birth Date:	

List of Consultants and Primary Care Doctor Information (Circle the referring doctor)

Primary Care Doctor Name:		Phone:		Fax:	
Consultant Name & Specialty:		Phone:		Fax:	
Consultant Name & Specialty:		Phone:		Fax:	

Chief Reason for Referral to Rheumatology (Main symptom, duration, location, treatments)

Past Medical History (Check formal diagnoses for which you may or may not take medications with approximate year of onset)

☐ High Cholesterol year	☐ Arrhythmia [irregular heart beat] year	☐ GERD/Acid Reflux year	☐ Depression year
☐ Hypertension/High BP year	☐ Stroke year	☐ Stomach ulcer year	☐ Anxiety Disorder year
☐ Type I Diabetes [Insulin] year	☐ Specific bleeding disorder year	☐ Fatty liver year	☐ Insomnia year
☐ Type II Diabetes year	☐ Pulmonary Hypertension year	☐ Hepatitis B year	☐ Obstructive Sleep Apnea year
☐ Thyroid Disease [type] year	☐ Interstitial Lung Disease year	☐ Hepatitis C year	☐ ☐ Alcoholism or ☐ Drug Addiction year
☐ Chronic Kidney Disease year	☐ Pleural Effusion year	☐ Celiac Sprue year	☐ Coccidiomycosis [confirmed Valley Fever] year
☐ Renal or Kidney Stones year	☐ Pericardial Effusion year	☐ Irritable Bowel Syndrome year	☐ ☐ HIV ☐ TB ☐ STD ☐ Lyme Disease [check] year
☐ ☐ Blood clots ☐ DVT ☐ PE [check] year	☐ Asthma year	☐ Seizure Disorder year	☐ Major Trauma year
☐ Coronary Artery Disease year	☐ COPD or Emphysema year	☐ Multiple Sclerosis year	☐ XRT/Radiation Therapy year
☐ Congestive Heart Failure year	☐ Cancer [type] year	☐ Migraine year	☐ Others year

Past Medical History - Rheumatology Specific (Check formal diagnoses and give year of onset)

☐ Osteoarthritis [location] year	☐ Fracture spine, hip, other Site: year	☐ Discoid Lupus year	☐ ☐ Ulcerative Colitis or ☐ Crohn's disease [check] year
☐ Degenerative discs in cervical spine year	☐ Fibromyalgia year	☐ Systemic Vasculitis [type] year	☐ Ankylosing Spondylitis year
☐ Degenerative discs in lumbar spine year	☐ Gout year	☐ Polymyalgia Rheumatica year	☐ ☐ Iritis ☐ Uveitis ☐ Scleritis [check] year
☐ Osteopenia year	☐ Rheumatoid Arthritis year	☐ Psoriasis year	☐ ☐ Autoimmune liver ☐ autoimmune thyroid disease [check] year
☐ Osteoporosis year	☐ Systemic Lupus Erythematosus [SLE] year	☐ Psoriatic Arthritis year	☐ Others year

Past Surgical History (List past major surgeries, year of surgery, left/right side if applicable)

1.	2.	3.
4.	5.	6.

Allergies to drug, latex or others (List Allergies and Reactions)

1.	2.	3.	4.
5.	6.	7.	8.

Current Medications (List prescription or over the counter medications you actively take)

	Name	Tablet Strength (Mgs, grams, etc.)	Frequency (once/day, twice/day, weekly, etc.)	Year it was started
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10				

Past Medications (Circle any past medications used that you do not take currently)

Medication	Year started and Year stopped	Benefit: Yes/No/Maybe	Major Side effects (if any)
Non Steroidal Anti-inflammatory [NSAIDS]: ☐ Ibuprofen ☐ Naproxen ☐ Diclofenac ☐ Relafen ☐ Indocin ☐ Clinoril ☐ Daypro ☐ Feldene ☐ Arthrotec ☐ Motrin ☐ Celebrex ☐ Lodine ☐ Meloxicam			
☐ Tylenol [regular/XS/arthritis] ☐ Tramadol ☐ ASA			
☐ Percocet ☐ Vicodin ☐ Oxycontin ☐ Other narcotics			
☐ Gabapentin ☐ Lyrica ☐ Flexeril ☐ Robaxin ☐ Soma ☐ Cymbalta			
☐ Colchicine ☐ Allopurinol ☐ Uloric ☐ Krystexxa			
☐ Medrol ☐ Prednisone ☐ Rayos			
☐ Synvisc ☐ Hyalgan ☐ Orthovisc ☐ Euflexxa injections			
☐ Gold shots ☐ Plaquenil ☐ Methotrexate ☐ Arava			
☐ Sulfasalazine ☐ Imuran ☐ Cellcept ☐ Cyclosporine			
☐ Enbrel ☐ Humira ☐ Cimzia ☐ Simponi ☐ Remicade			
☐ Orencia ☐ Actemra ☐ Xeljanz ☐ Otezla			
☐ Rituxan ☐ Cytoxan ☐ Stelara ☐ Benlysta			
☐ Fosamax ☐ Actonel ☐ Boniva ☐ Reclast ☐ Prolia ☐ Forteo			

Family History (Check if family member has a CONFIRMED diagnosis and give relationship)

☐ Osteoarthritis Who?	☐ Psoriasis Who?	☐ Polymyalgia Rheumatica Who?	☐ Blood clots Who?
☐ Osteoporosis Who?	☐ Crohn's Disease Who?	☐ Systemic Vasculitis Who?	☐ Hypertension Who?
☐ Gout Who?	☐ Ulcerative Colitis Who?	☐ Parent with Hip/Spine fracture Who?	☐ Diabetes Who?
☐ Rheumatoid Arthritis Who?	☐ Ankylosing Spondylitis Who?	☐ Cancer Who?	☐ Heart Disease Who?
☐ Systemic Lupus Who?	☐ Iritis or Scleritis Who?	☐ Tuberculosis Who?	☐ Stroke Who?

Social History (Check or Circle if Applicable)

1.	**Cigarette Smoking**	Never			7.	**Birth Control measure, if any**	
		Current	# per day	Total years smoked:	8.	**Currently Breastfeeding**	Yes / No ☐ ☐
		Former	Quit date	Total years smoked:	9.	**Last Menstrual: Period**	**Age at Menopause:**
2.	**Alcohol Use**	Yes / No ☐ ☐	# Drinks/week: Beer/Wine/Spirit		10	**Pregnancy**	# Pregnancies # Miscarriages
3.	**Drug Abuse (marijuana, illicit drugs, prescription narcotics)**	Yes / No ☐ ☐	Type of Drug:		11	**Last Eye Exam [date]:** **Mammogram: [year]**	**Colonoscopy: [year]** **PAP smear: [year]**
4.	**Exercise and type of exercise**	Yes / No ☐ ☐	Duration and Frequency		12	**Last Bone Density: [date]**	**Last TB test & result [date]:**
					13	**Do you have a medically related lawsuit pending?**	Yes / No ☐ ☐ Reason:
5.	**Marital Status**	Single ☐	Married ☐	Domestic Partnership ☐	14	**Are you on Disability or Applying for it?**	Yes / No ☐ ☐ Reason:
6.	**Trying to Conceive**	Yes / No ☐ ☐			15	**Current Occupation**	

Systems Review (SELECT RECENT OR ACTIVE symptoms associated with the REASON FOR REFERRAL)

GENERAL	**NECK**	**GASTROINTESTINAL**	**MUSCULOSKELETAL**
☐ Weight loss: [amount/time]	☐ Hoarseness [excessive]	☐ Nausea	☐ Joint pain location
☐ Weight gain: [amount/time]	☐ Enlarged Node or large thyroid	☐ Abdominal Pain	☐ Joint swelling
☐ Fatigue	**RESPIRATORY**	☐ Vomiting	☐ Morning stiffness duration
☐ Fever	☐ Cough [dry or productive]	☐ Vomiting blood	☐ Muscle Pain location
SKIN	☐ Shortness of breath at rest	☐ Blood in stools	☐ Low back pain
☐ Rash	☐ Shortness of breath at exertion	☐ Black stools	☐ Neck pain
☐ Raynaud's [color changes in hands/feet when cold]	☐ Coughing of blood [hemoptysis]	☐ Hemorrhoids	**NEUROLOGIC and PSYCHIATRIC**
☐ Hair loss [patchy or thinning]	☐ Wheezing	☐ Heartburn [current]	☐ Active Insomnia
SPECIAL SENSES	☐ Snoring	☐ Difficulty swallowing	☐ Localized loss of muscle power
☐ Hearing Loss	☐ Sputum production [colored]	☐ Diarrhea	☐ Numbness: location
☐ Dry Eyes	**BREAST**	**GENITOURINARY**	☐ Tingling: location
☐ Eye Pain with Eye Redness	☐ Mass or Lump or Discharge	☐ Blood in urine	☐ Difficulty with speech
☐ Double Vision	**CARDIOVASCULAR**	☐ Painful urination	☐ Active Anxiety
☐ Vision Loss [blindness]	☐ Chest Pain [new and active]	☐ Flank pain	☐ Active Depression
☐ Dry mouth [excessive]	☐ Leg Swelling [new or excessive]	☐ Genital ulcer	**ENDOCRINE**
☐ Oral Sores [recurrent]	☐ History of Heart Murmur	☐ Prostate trouble	☐ Anorexia
☐ Chronic Sinusitis	**HEMATOLOGIC**	☐ Foamy urine	☐ Cold intolerance [excessive]
☐ Nosebleeds [frequent]	☐ Abnormal bleeding or bruising		

HEALTH QUESTIONNAIRE:
Please select and circle a number for each activity after reading about the task.
0 – no difficulty, 1 – some difficulty, 2 - much difficulty, 3 – unable to do
If you do not wish to fill this information, please indicate "Do not wish to fill".

1.	Dress yourself	11.	Take a bath	Do you use these?	
2.	Shampoo hair	12.	Get on and off toilet	☐	Cane
3.	Stand up from chair	13.	Reach and get down a 5lb object from above your head	☐	Walker
4.	Get in and out of bed	14.	Bend down to pick up	☐	Crutches
5.	Cut your meat	15.	Open car doors	☐	Wheelchair
6.	Lift a full cup or glass to your mouth	16.	Open previously opened jars	☐	Built up chair
7.	Open a new milk carton	17.	Turn faucets on and off	☐	Built up utensils
8.	Walk outdoors on flat ground	18.	Run errands and shop	☐	Devices to dress
9.	Climb up 5 steps	19.	Get in and out of car	☐	Raised toilet seat
10	Wash and dry your body	20.	Do chores (vacuum / yard work)	☐	Bathtub bar or seat
				☐	Long-handled appliances for reach

VISUAL ANALOG PAIN SCALE

Please report current pain intensity by drawing a perpendicular line on the horizontal line below.

Worst imaginable pain 10 ---------- **0 No pain**

Office Use Only