

PEDIATRIC RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

ALLERGIES:

MEDICATION	Type of Reaction	FOOD	Type of Reaction

PETS: _____

TRAVEL: in the last year, with dates of travel

Out of the Country? _____

Out of the State? _____

MEDICATIONS: name and dosage

Currently taking

1. _____

2. _____

3. _____

4. _____

5. _____

Taken within the last 4 months

1. _____

2. _____

3. _____

4. _____

5. _____

Dx _____

BCode _____

FU _____

PAST MEDICAL HISTORY:

Other Medical Diagnosis	Date
Surgery	Date
Hospitalization	Date

FAMILY HISTORY: Please circle if alive and well, if deceased write what age and cause of death

M _____ MGM _____
 F _____ MGF _____
 B (how many) _____ PGM _____
 S (how many) _____ PGF _____

Please specify

M (mother)

F (father)

B (brother)

S (sister)

MGM (maternal grandmother)

MGF (maternal grandfather)

PGM (paternal grandmother)

PGF (paternal grandfather)

C (cousin)

MA (maternal aunt)

MU (maternal uncle)

PA (paternal aunt)

PU (paternal uncle)

Rheumatoid Arthritis _____

Other Arthritis _____

Ankylosing Spondylitis _____

Back Pain _____

Psoriasis _____

Systemic Lupus Erythematosus _____

Raynaud's Disease _____

Vasculitis _____

Scleroderma _____

Dermatomyositis _____

Sjogren's Syndrome _____

Fibromyalgia/Chronic Fatigue _____

Sarcoidosis _____

Recurrent Fever _____

Recurrent Miscarriages _____

Crohn's / Ulcerative Colitis _____

Celiac Disease _____

Irritable Bowel _____

Thyroid Disease _____

Headache/Migraine _____

High Blood Pressure _____

Stroke _____

Heart Attack _____

Heart Disease _____

Depression _____

Bipolar/psychiatric dis _____

Cancer (type) _____

Other _____

What is the REASON for today's visit? _____

REVIEW OF SYSTEMS:

Has your child had any of the following symptoms recently?

- | | |
|-----------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Unexpected weight gain or loss (amount)_____ | <input type="checkbox"/> Sun sensitivity |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Cold intolerance |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Numbness or tingling (where)_____ |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Dry eyes or mouth | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Limp or difficulty walking |
| <input type="checkbox"/> Palpitation/fast heart beat | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pallor or anemia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bruising or bleeding |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Difficulty or pain when swallowing | <input type="checkbox"/> Sleep problem |
| <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Moody or tearful |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive worries |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Decreased school performance |
| <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Difficulty concentrating/poor memory |
| <input type="checkbox"/> Menstrual abnormality | <input type="checkbox"/> Frequent school absences |

HOUSEHOLD COMPOSITION: List the AGES of all people living with your child at home

_____	_____	_____	_____	_____	_____	_____	_____	_____
father/step (mother2)	mother/step (father2)	patient	brother/sister (half)	br/sis (half)	br/sis (half)	br/sis (half)		

Father's occupation: _____

Mother's occupation: _____

Patient's school and grade: _____ Smoking: Y N