Central Florida Rheumatology Consultants

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NEW PATIENT INTAKE FORM

Demographics:

Date of Appointment:________/________/________

Name:____ DOB:________/________/________

Age:_____________________ Sex:____

Address:____
Street City State Zip

Mobile Phone:___________________________________ Best Contact Number:____________________________

Email Address:______________________________________ Birthplace:___________________________________

Occupation (if retired, prior occupation):____

Marital Status (circle): Never Married Married Divorced Separated Widowed

Race (circle): Caucasian(white) Hispanic African American Asian Other:_____________________

Primary Care Provider:____

Reason or concerns prompting rheumatology referral:____

____

Social History:

Do you currently smoke? __________________________ Are you a previous smoker?_____________________

If yes, how many years have you smoked?___________ How many packs per day?______________________

Do you drink alcohol?_____________________________ if yes, how many per week?_____________________

Do you use any recreational drugs (not prescribed to you):____

If yes, please list:____

Do you exercise regularly?_____________if yes, what type of exercise?________________________________

Drug Allergies: Please list any drug allergy and the type of reaction to that medication.____

____

____

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Current Medications: List all meds you are taking, including over-the-counter medications:

Drug Name:	Dose (strength and # of pills per day):	How long have you been on this medication:

Previous Surgeries:

Type:	Year:	Reason:

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Medical History: Please circle if you have been diagnosed with any of the following:

Diabetes Psoriasis Rheumatoid Arthritis Lupus Stroke Kidney Disease Ulcerative Colitis

Crohn's Disease COPD Emphysema Asthma Heart Disease High Blood Pressure Hepatitis

High Cholesterol Diverticulitis HIV/AIDS Tuberculosis Other:____________________________________

Other Autoimmune Disease?____

Previous Cancer?________ If yes, what type?________________________________ what year?________________

If previous cancer, describe treatment?____

Any Previous Fractures?______ If yes, describe (include treatment):______________________________________

Family History: Do any blood relatives have any history of the following: (Please list relationship to you if yes)

Psoriasis?____ Lupus (SLE)?_________________________________

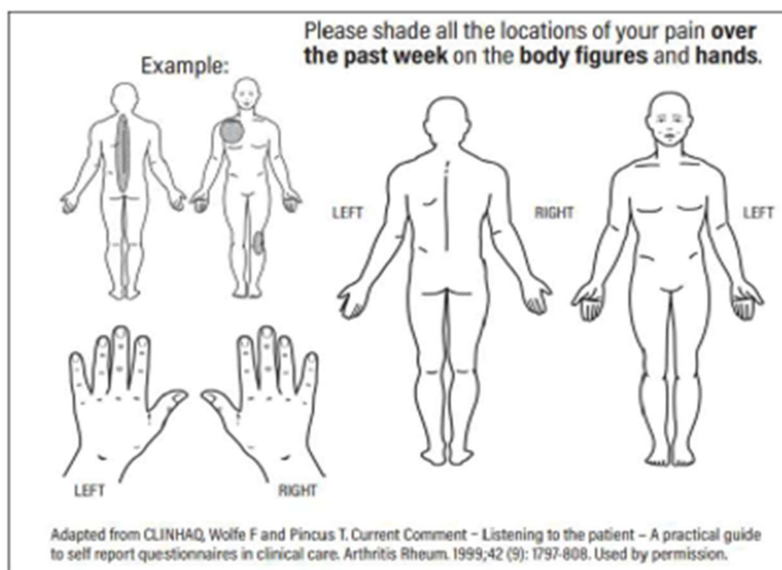
Rheumatoid Arthritis?_______________________________ Ankylosing Spondylitis?_______________________

Gout?____ Osteoporosis?_______________________________

Any other family history we should be aware of?____

____

If applicable, please indicate areas of pain on the diagram below:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

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Review of Systems: Please review the following list. Circle any symptoms you are having.

Constitutional: Weight Loss Weight Gain Fatigue Fever Night Sweats

Eyes: Pain Redness Dryness

Ears-Nose-Throat: Nosebleeds Sores in Mouth Mouth Dryness Difficulty Swallowing

Respiratory: Shortness of Breath Cough

Gastrointestinal: Nausea Vomiting Persistent Diarrhea Heartburn

Genitourinary: Blood in Urine

Musculoskeletal: Morning stiffness (how long?______mins_____hrs) Joint Pain Joint Swelling Muscle Weakness Muscle Tenderness

Skin: Easy Bruising Rash Sun Sensitivity Hair Loss Color change of hands/feet

Neurological System: Headaches

Hematologic/Lymphatic: Swollen Glands Anemia

WOMEN ONLY: Number of pregnancies?___________________Number of miscarriages?______________

HIV Screening: HIV screening is recommended by the CDC for all patients at least once in their lifetime.

As part of a public health initiative, Central Florida Rheumatology Consultants has partnered with Central Florida Health Care Services (CFHCS) to provide HIV screening to all patients at no cost. CFHCS is a not-for-profit organization that is working with the Florida Department of Health to provide Screening services to all patients who wish to be tested or have counseling regarding HIV risk and prevention. If you are interested in these services, please answer the questions below.

Your answers to these questions, like all protected health information (PHI), are confidential. If you answer “yes” to any of the following questions, CFHCS will provide you with free resources for testing, counseling and prevention services, including free HIV testing.

Option: ☐ Decline to answer all

1. Have you previously been tested for HIV? ☐ Yes ☐ No
2. Are you at risk of contracting HIV or Hepatitis through blood exposures or sexual activities? ☐ Yes ☐ No ☐ Decline to answer
3. Would you like to be provided free testing for HIV? ☐ Yes ☐ No ☐ Decline to answer
4. Would you like to be provided no cost counseling and preventative therapy for HIV? ☐ Yes ☐ No ☐ Decline to answer

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PAST RHEUMATOLOGY MEDICATIONS

Please review this list of Rheumatology medications. As accurately as possible, note the medications you have taken, how long you were on the medication, the results of taking the medication and list any reaction you may have had. **If you have not been previously diagnosed with an autoimmune disorder, osteoporosis or gout you may skip this form.**

Treatment for Autoimmune Diseases: (SKIP IF NOT APPLICABLE)

Drug name	IV, injection, oral	Did medication help? (yes/no)	Why Stopped?	Reactions, if any
Cimzia (certolizumab Pegol)				
Simponi (golimumab)				
Plaquenil (hydroxychloroquine)				
Methotrexate				
Imuran (azathioprine)				
Sulfasalazine				
Cytoxan (cyclophosphamide)				
Enbrel (etanercept)				
Remicade (infliximab)				
Actemra (tocilizumab)				
Taltz (ixekizumab)				
Cosentyx (secukinumab)				
Otezla (apremilast)				
CellCept (mycophenolate)				
Arava (leflunomide)				
Humira (adalimumab)				
Xeljanz (tofacitinib)				

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Rituxan (rituximab)				
Orencia (abatacept)				
Rinvoq (upadacitinib)				
Olumiant (baricitinib)				
Kevzara (sarilumab)				
Saphnelo (anifrolumab-fnia)				
Benlysta (belimumab)				
Tremfya (guselkumab)				
Skyrizi (risankizumab-rzaa)				
Bimzelx (bimekizumab-bkzx)				

Treatment for Osteoporosis: (SKIP IF NOT APPLICABLE)

Drug Name	**Did the medication help? (yes/no)**	**Why stopped?**	**Reactions**
Estrogen			
Fosamax (alendronate)			
Evista (raloxifene)			
Calcitonin			
Actonel (risedronate)			
Prolia (denosumab)			
Forteo (teriparatide)			
Evenity (romosozumab-aqqg)			
Tymlos (abaloparatide)			

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Treatment for Gout: (SKIP IF NOT APPLICABLE)

Drug Name:	**Did the medication help? (yes/no)**	**Why Stopped?**	**Reactions**
Benemid (probenecid)			
Colcrys (Colchicine)			
Allopurinol			
Uloric (Febuxostat)			
Krystexxa (pegloticase)			