Central Florida Rheumatology Consultants, LLC

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ABIM board certified Adult Rheumatologist

Please fill out all pages as completely as possible.

NAME _____ Date of Birth _____ Age_____

DATE _____ Referring Physician _____

CHIEF COMPLAINTS:

_____

_____

_____

PAST MEDICAL HISTORY *(*Have you had these?)

Rheumatologic

Rheumatoid Arthritis	Yes _____ No _____	Ulcerative Colitis	Yes _____ No _____
Lupus	Yes _____ No _____	Mixed Connective Tissue Disease	Yes _____ No _____
Scleroderma	Yes _____ No _____	Interstitial Lung Disease	Yes _____ No _____
Myositis	Yes _____ No _____	Gout	Yes _____ No _____
Vasculitis	Yes _____ No _____	Kidney stones	Yes _____ No _____
Psoriasis	Yes _____ No _____	Other Autoimmune conditions.	Yes _____ No _____
Crohn's Disease	Yes _____ No _____		

RESPIRATORY:

Bronchial Asthma	Yes _____ No _____
COPD/Emphysema	Yes _____ No _____
Pneumonia	Yes _____ No _____
Lung cancer	Yes _____ No _____
Tuberculosis	Yes _____ No _____
Pulmonary embolism	Yes _____ No _____
Blood clot in legs	Yes _____ No _____

ENDOCRINE

Diabetes	Yes _____ No _____
High cholesterol	Yes _____ No _____
Thyroid disorder	Yes _____ No _____

CARDIAC:

Hypertension	Yes _____ No _____
Heart attack	Yes _____ No _____
Congestive heart failure	Yes _____ No _____
Heart bypass surgery	Yes _____ No _____
Echocardiogram	Yes _____ No _____

GASTROINTESTINAL :

Peptic Ulcer Disease	Yes _____ No _____
Hepatitis	Yes _____ No _____
Gall Bladder Disease	Yes _____ No _____
Bowel Disorder	Yes _____ No _____

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NEUROLOGICAL

Stroke Yes _____ No _____

Epilepsy Yes _____ No _____

VASCULAR

Peripheral Vascular Disease Yes _____ No _____

Carotid Artery Disease Yes _____ No _____

UROLOGICAL

Kidney Disease Yes _____ No _____

Prostate problem Yes _____ No _____

OTHERS:

Arthritis Yes _____ No _____

Bleeding disorders Yes _____ No _____

Cancer Yes _____ No _____

LIST ANY OTHER DISEASES:

_____

_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

_____

_____

_____

ALLERGIES *(*To the following medications, please check)

Penicillin _____ Sulfa _____ Aspirin _____ Shellfish _____ IV Dye _____

Other medications: Please name _____

Please specify reaction to above medications: _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

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FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

YES	NO		WHO	YES	NO		WHO
____	____	Rheumatoid Arthritis	_____ ;	____	____	Myositis	_____
____	____	Lupus	_____ ;	____	____	Vasculitis	_____
____	____	Scleroderma	_____ ;	____	____	Psoriasis	_____
___	____	Crohn's Disease	_____ ;	____	____	Gout	_____
____	____	Ulcerative Colitis	_____ ;	____	____	Other Autoimmune conditions	_____
____	____	Mixed Connective Tissue Disease	_____ ;				
__	____	Diabetes	_____ ;	____	____	Cancer	_____
____	____	High Blood Pressure	_____ ;	____	____	Stroke	_____
____	____	Heart Disease	_____ ;	____	____	Abnormal Bleeding	_____

SOCIAL HISTORY

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Tobacco use:

Are you currently using tobacco? Yes ____ No ____# packs per day _____ for how many years?_____
How long after you wake up do you smoke your first cigarette?_____
How ready are you to quit? _____ Ready to quit? _____ Thinking about it? _____ Not ready to quit?
Did you use tobacco in the past? Yes ____ No ____# packs per day _____
For how many years?_____ Date you quit _____

Alcohol Use

Do you use alcohol regularly? Yes_____ No_____
How much per day? _____ For how many years?_____
Did you use alcohol in the past? Yes ____ No _____
How much per day? ____ For how many years?_____ Date you quit_____

Pets at home:_____ All occupational exposures:_____
List places lived:_____ Travel in last 2 years:_____