AchyJoint Rheumatology- New Patient Form

Name_____ Date of Birth_____

Reason for Visit: _____

Current Healthcare Providers: (Primary care doctor and Specialists)

Primary Care Doctor:	Specialist:
Specialist:	Specialist:

Current and Past Medical Conditions: (Dates of Diagnosis)

Current Medications and Dosages: (Prescribed, Supplements, Herbal/Alternatives)

Allergies: (List reaction) _____

Past Surgeries/Hospitalizations: (Diagnosis, Date, and Hospital)

Social History:

Occupation:_____Marital Status: _____

Tobacco use:_____Alcohol use:_____Drug use:_____

Number of
Pregnancy:_____Livebirths:_____Miscarriages:_____

Family History: (Include history of autoimmune conditions such as rheumatoid arthritis, lupus, vasculitis, etc..)

	Rheumatoid arthritis	Lupus	Sjogren disease	Osteoarthritis	Hypertension	Diabetes	Thyroid disease	Cholesterol	Heart Disease	Stroke	Asthma/ COPD
Mother											
Father											
Sibling											
Sibling											
Sibling											
Sibling											
Sibling											
Cousin											
Cousin											
Aunt											
Uncle											

Additional Family information:_____
_____

_____

_____

_____

Prior Rheumatologist (Name and Address):_____

Where you ever treated with: (date and duration of medication)

Methotrexate/Plaquenil/Sulfasalazine/Leflunomide:_____

Enbrel/Humira/Simponi/Remicade/Cimzia:_____

Abatacept/Rituximab/Actemra/Xeljanz/Baricitinib:_____

Additional information:_____

Signature:_____Date:_____