The Austin Diagnostic Clinic Rheumatology Department
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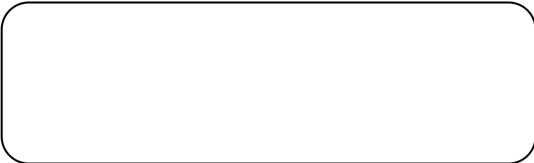

RHEUMATOLOGY NEW PATIENT FORM

Name: ______________________________ Date of Birth: ____________________

Primary Care Physician: ____________________ Referred by: ____________________

Surgical History

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

Medications

If you are a new patient with The Austin Diagnostic Clinic, please list all medications and the dosages:

Drug Name	Dose	How Often

Allergies

Please check all allergies:

____ Medications: ____

____ Foods: ____

____ Tapes ____Novocain ____Anesthetics ____ Other: ______________________________

What types of reactions have you experienced?

____

____

Family History

List any medical problems for the following family members:

Father: ____

Mother: ____

Siblings: ____

Social Information

Occupation: ______________________________

Marital Status: ____Single ____Married ____Divorced ____Widowed

Children: ____Yes ____No If yes, how many? ______

Do you smoke currently? ____ Yes ____ No How many packs per day? ______ For how long? _________

Have you smoked previously? ____ Yes ____ No If yes, how many packs/day? ____ When did you quit? _______

Do you use illicit drugs? ____Yes ____No

Do you drink alcoholic beverages? ____Yes ____No If yes, how often? __________

Have you ever had a blood transfusion? ____Yes ____No If yes, what year was the transfusion? _______

Do you exercise? ____Yes ____No If yes, what type of exercise? ________________________________

How many times/week? ____

Please check if you are experiencing any of the following:

	Fever, chills, night sweats		Diarrhea
	Unintended weight loss		Constipation
	Visual problems		Trouble swallowing
	Dry eyes		Abdominal pain
	Dry mouth		Blood in urine
	Sores in mouth or nose		Pain with urination
	Swollen glands		History of miscarriages
	History of blood clots		History of kidney stones
	Chest pain		Rash (If yes, is it worse in the sunlight? ___Yes ___No)
	Leg swelling		Hair loss
	Cough		Color changes in fingers when exposed to cold
	Shortness of breath		Numbness/tingling in any extremities
	History of fluid in your lungs or around your heart		Muscle weakness
	Depression		Nausea or vomiting
	Anxiety		History of seizures

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone by either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my condition with x-ray, examination or photographs of infections as necessary.

___________________________________ ___________________________________

Date Signature