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?

_____Unexpected weight gain or loss (amount)_____
_____Fever
_____Tiredness
_____Red eyes
_____Dry eyes or mouth
_____Anorexia
_____Sore throat
_____Mouth sores
_____Swollen glands
_____Chest pain
_____Palpitation/fast heart beat
_____Heart murmur
_____Shortness of breath
_____Cough
_____Wheezing
_____Difficulty or pain when swallowing
_____Stomach pain _
_____Diarrhea
_____Nausea
_____Vomiting
_____Blood in the urine
_____Menstrual abnormality

_____Sun sensitivity
_____Cold intolerance
_____Numbness or tingling (where)_____
_____Skin rash
_____Hair loss
_____Joint pain
_____Joint swelling
_____Muscle pain
_____Muscle weakness
_____Limp or difficulty walking
_____Back pain
_____Pallor or anemia
_____Bruising or bleeding
_____Dizziness
_____Headache
_____Sleep problem
_____Moody or tearful
_____Excessive worries
_____Depression
_____Decreased school performance
_____Difficulty concentrating/poor memory
_____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**