NEW PATIENT SECTION

NAME: _____ **AGE:** _____ **REFERRING M.D.:** _____ **DATE:** _____

REASON FOR VISIT: _____

OCCUPATION: _____ **WHEN DID YOUR PROBLEM START?**_____

ASSOCIATED SYMPTOMS:

Morning stiffness: _____ min / hour
☐ <15 min ☐ <1 hour ☐ >1 hour

☐ Joint Pain ☐ Joint Swelling
☐ Fatigue ☐ Depression
☐ Sleep problem ☐ High stress

☐ Sun exposure gives rash
☐ Nervous breakdown
☐ Fluid around heart or lung
☐ Facial Rash ☐ Skin Rash
☐ Mouth ulcer ☐ Seizure
☐ Kidney problem ☐ Blood in urine

☐ Anemia ☐ Low blood counts
☐ Miscarriages ☐ Blood clots
☐ Fever ☐ New hair loss
☐ Chest pain ☐ Short of breath
☐ Enlarged glands ☐ Stomach pain
☐ Cold fingers ☐ Skin nodules

TYPE OF PAIN:
☐ Sharp ☐ Dull ☐ Achy ☐ Shooting ☐ Burning

SEVERITY OF PAIN:
Place a mark on the line to indicate severity of your pain:

No Pain |---1---2---3---4---5---6---7---8---9---| Worst pain

DURATION OF PAIN:
☐ Few seconds ☐ Few minutes ☐ Few hours ☐ Whole day

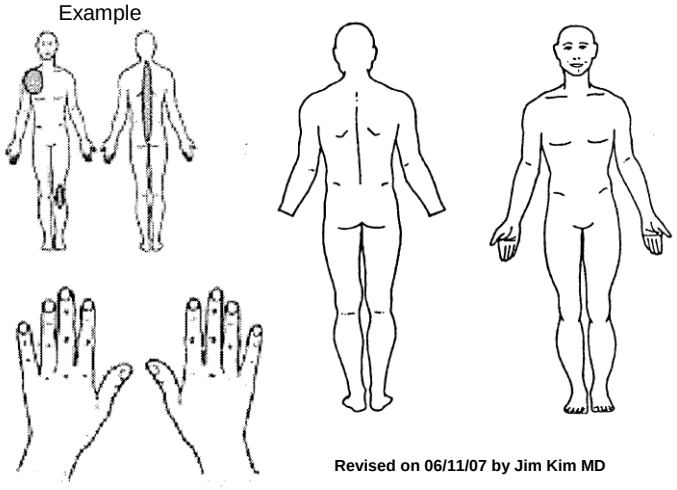
TIME OF PAIN:
☐ In morning ☐ In afternoon ☐ In evening ☐ Bed time

WHAT MAKES IT WORSE:
☐ Activity ☐ Cold ☐ Moving ☐ Weather ☐ Everything

WHAT MAKES IT BETTER?:
☐ Inactivity ☐ Heat ☐ Activity ☐ Resting ☐ Medicine

PLEASE SHADE ALL THE LOCATIONS OF YOUR PAIN

Example



Revised on 06/11/07 by Jim Kim MD

CURRENT SYMPTOMS: (Circle Yes or No)

Constitutional	Head	Eyes	Nose/Mouth	Respiratory	Cardiovascular
Y N Fatigue	Y N New hair loss	Y N Redness	Y N Nosebleeds	Y N Short of Breath	Y N Pain in Chest
Y N Fever	Y N Headache	Y N Loss of vision	Y N Sores in mouth	Y N Cough	Y N Irregular Beat
Y N Weight Loss	Y N Scalp pain	Y N Dryness	Y N Dryness	Y N Wheezing	Y N Poor **C**irculation

Vascular	Gastrointestinal	Genitourinary	Metabolic	Neuro/Psych
Y N Cool Extremity	Y N Nausea	Y N Dysuria	Y N Hair Loss	Y N Sleep Problem
Y N Edema	Y N Blood in Stool	Y N Freq Urination	Y N Hypoglycemic	Y N Anxiety
Y N Raynaud's	Y N Diarrhea	Y N Hematuria	Y N	Y N

OTHER MEDICAL PROBLEMS

_____ _____
_____ _____
_____ _____

SURGERY

_____ _____
_____ _____
_____ _____

IF FEMALE, NUMBER OF PREGNANCY: _____

DO YOU SMOKE? ☐ No ☐ Yes
DO YOU DRINK ALCOHOL? ☐ No ☐ Yes
DO YOU USE STREET DRUGS? ☐ No ☐ Yes

FAMILY HISTORY OF:
Rheumatoid Arthritis ☐ No ☐ Yes
Lupus ☐ No ☐ Yes

DRUG ALLERGIES: ☐ No ☐ Yes To What? _____

CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____

******For Staff Use*** Reviewed by:***