WALL STREET MEDICAL

Name:

DOB:

HSN:

Rheumatology New Patient Intake Form

Family Physician:

Pharmacy: **Drug Allergies?**

Occupation: **Insurance?**

Personal Medical History (please check all that apply):

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart attack / angina
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Psoriasis
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ COPD
- ☐ Asthma
- ☐ Hypothyroidism/Hyperthyroidism
- ☐ Osteoarthritis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Depression / Anxiety
- ☐ Blood Clots
- ☐ History of miscarriage
- ☐ Cancer (type:)
- ☐ Other:

Previous Surgeries / Hospitalizations:

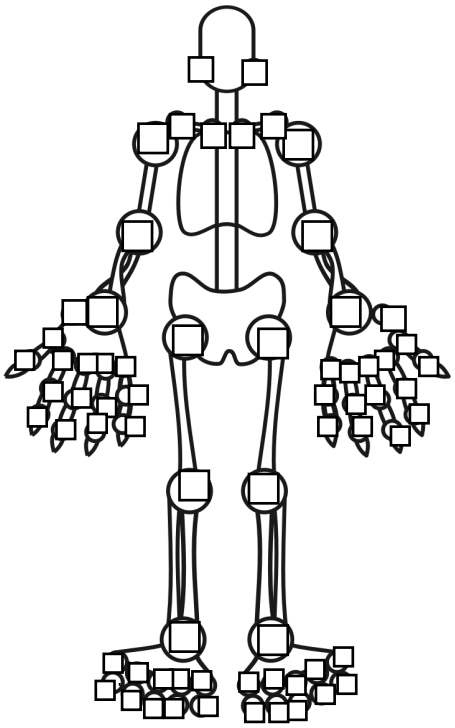
Medication List (including vitamins, supplements, and birth control):

1	8
2	9
3	10
4	11
5	12
6	13
7	14

Have you experienced any of the following?

- ☐ Joint pain/stiffness
- ☐ Joint swelling Muscle pain/stiffness
- ☐ Skin sensitivity to sun
- ☐ Psoriasis
- ☐ Other skin rashes
- ☐ Hands changing colour (white/red/blue) in cold weather
- ☐ Mouth sores/ulcers
- ☐ Extreme dry eyes requiring daily eye drops
- ☐ Dry mouth
- ☐ Severe heartburn requiring medication
- ☐ Dry cough or coughing up blood
- ☐ Weight loss (if yes, how much _____)
- ☐ Fevers >38 C/100.4 F

Please Indicate your pain/swelling over the past month on the diagram:



Smoking History

☐ Never smoked

☐ Former smoker: Quit year: _____ Average amount per day: _____

☐ Current smoker: Amount per day: _____ Duration: _____

Alcohol Use

☐ None ☐ Average drinks per week: _____

Family History (please check all that apply)

☐ Rheumatoid arthritis	☐ Systemic lupus erythematosus (SLE)
☐ Psoriatic arthritis	☐ Osteoporosis
☐ Psoriasis	☐ Fibromyalgia
☐ Ankylosing spondylitis	☐ Multiple sclerosis
☐ Inflammatory bowel disease (Crohn's / Colitis)	☐ Other autoimmune disease: _____

Any other medical history we should be aware of?