ARAPB – NEW PATIENT SURVEY

Answer each line and question in the space provided. Circle/check the best answer. Fill out both sides of this form. This survey will help the doctor evaluate, diagnose and treat you. Write your comments & questions on next page.

Name:_______________________________Age:______ Date:___________ Referred by: _______________

Email: @ Birthdate: / / My Primary Care MD:

Emergency Contact: Relationship: Phone#: Work #:

WT

BP

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ABOUT YOUR ARTHRITIS OR PROBLEM

What is your problem?____

Symptoms First Began: Month ______Year________ Initial Symptom(s): ___________________________

Where: ☐Fingers ☐Hands ☐Wrist ☐Elbow ☐Shoulder ☐Knee ☐Feet ☐Hip ☐Back ☐Neck

First Diagnosed as: ______________________ By Dr._______________ Where?_______________

What tests were Abnormal: ☐ANA ☐Sed Rate ☐RF (rheumatoid factor) ☐Uric Acid ☐Biopsy

This week I am doing: ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor ☐Better ☐Much Worse

I am mostly concerned about:____

Im having:☐Pain ☐Stiffness ☐Aching ☐Soreness ☐Muscle pain ☐Swelling ☐Weakness ☐Numbness

How long is your Morning Stiffness? ☐None ☐15min ☐30min ☐45min ☐1hr ☐2hr ☐4hr ☐All Day

My Sleep is: ☐Great ☐Normal ☐Fair ☐Poor ☐Very Poor Sleeping aids used? ☐No ☐Yes

☐Cant Fall asleep ☐Cant Stay Asleep ☐Early Waking ☐Snoring ☐Sleep apnea ☐Restless Legs ☐Pain

In PAST WEEK, how much pain have you had? (circle a number or put a mark thru the line below)

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** *MOST SEVERE PAIN*

Mild *Moderate* *Severe*

Medical History				**Past Surgeries**	**Year**
	☐ Skin Problems	☐ Pancreatitis	☐ Osteoporosis		
☐ Seizures	☐ Psoriasis	☐ Stomach Ulcers	☐ Polymyositis	☐ Neck Surgery	
☐ Stroke ☐ TIA	☐ Thyroid Problem	☐ Colitis/Bowel probs	☐ Scleroderma	☐ Back Surgery	
☐ Neuropathy	☐ Cancer ☐Chemo	☐ Glaucoma ☐Cataract	☐ Fibromyalgia	☐Joint replaced	
☐ Depression	☐ Pneumonia	☐ Accidents ☐ Falls	☐ Lupus	☐ Arthroscopic	
☐ Alcohol abuse	☐ Lung Disease	☐ Miscarriage(s)	☐ Gout	☐ Tonsillectomy	
☐ Hypertension	☐ Asthma ☐COPD	☐ Blood Clots	☐ Vasculitis	☐ Appendctomy	
☐ Diabetes	☐ Tuberculosis	☐ TMJ/Jaw problems	☐ Carpal Tunnel	☐ Gall Bladder	
☐ Anemia	☐ (+) TB skin test	☐ Migraine	☐ Sjogren syndrome	☐ Hysterectomy	
☐ Heart Attack	☐ Gallstones	☐ Sleep apnea	☐ Rotator Cuff	☐ Heart Bypass	
☐ Heart Failure	☐ Hepatitis	☐ Osteoarthritis	☐Bursitis ☐Tendinitis	☐ Hernia repair	
☐ Irregular Heart	☐ Kidney stones	☐ Rheumatoid arthritis	☐ Juvenile Arthritis	☐ Breast surgery	
☐ High Cholesterol	☐ Kidney disease	☐AnkylosingSpondylitis	☐ Spine problems	☐ Fracture(s)	

DO YOU HAVE?				
	☐ Bursitis	☐ Eye pain	☐ Swallowing Problem	☐ Wheezing
☐ Weight loss____lbs	☐ Nodules	☐ "Pink" (red) eyes	☐ Eating disorder	☐ Purple/blue fingers
☐ Weight gain____lbs	☐ Skin rash/sores	☐ Vision Problems	☐ Peptic ulcer	☐ Edema in legs/feet
☐ Fever	☐ Tight skin	☐ Nosebleeds	☐ Gastritis ☐ Reflux	☐ Pain on urination
☐ Weakness	☐ Hives/Welts	☐ Chronic Sinusitis	☐ Diarrhea	☐ Bladder problem
☐ Fatigue	☐ Itching	☐ Ringing in ears	☐ Constipation	☐ Vaginal Discharge
☐ Night sweats	☐ Hair falling out	☐ Jaw Pain	☐ Irritable bowel	☐ Menstrual Problem
☐ Joint pains	☐ Abnormal nails	☐ Hearing problems	☐ Diverticulitis	☐ Numbness
☐ Morning stiffness	☐ Easy Bruising	☐ Swollen glands	☐ Blood in stool	☐ Headaches
☐ Pain in muscles	☐ Sore throat	☐ Poor appetite	☐ Hemorrhoids	☐ Dizzy spells
☐ Back Pain	☐ Sores in mouth	☐ Heartburn	☐ Jaundice	☐ Loss of Memory
☐ Heel Pain	☐ Dental problems	☐ Indigestion	☐ Chest pain Sharp?	☐ Anxiety
☐ Tendinitis	☐ Dry mouth	☐ Nausea	☐ Cough	☐ Depression
	☐ Dry eyes	☐ Vomiting	☐ Short of Breath	☐ Difficulty sleeping

What Medicine(s) are you Allergic To?

List all prescription medications you are now taking (include over the counter meds and natural/herbal pills)

Drug Name	Dose	How many times/day	Drug Name	Dose	How many times/day
1.			5.		
2.			6.		
3.			7.		
4.			8.		

My Preferred Pharmacy: Pharmacy Phone #:

Name

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS/VACCINES? (Check all you have taken)

☐ Antacids
☐ Axid
☐ Cytotec
☐ Pepcid
☐ Prevacid
☐ Prilosec
☐ Protonix
☐ Nexium
☐ Tagamet
☐ Zantac
☐ Advil
☐ Aleve
☐ Anacin
☐ Anaprox
☐ Ansaid
☐ Arthrotec
☐ Aspirin

☐ Bextra
☐ Celebrex
☐ Clinoril
☐ Daypro
☐ Disalcid
☐ Dolobid
☐ Ecotrin
☐ Feldene
☐ Ibuprofen
☐ Indocin
☐ Lodine
☐ Mobic
☐ Motrin
☐ Naproxen
☐ Relafen
☐ Prednisone
☐ Tolectin
☐ Vioxx

☐ Orudis Etodolac
☐ Voltaren
☐ Colchicine
☐ Allopurinol
☐ Uloric Febuxostat
☐ Krystexxa
☐ Actemra
☐ Arava
☐ Atabrine
☐ Auranofin
☐ Azathioprine
☐ Azulfidine
☐ Benlysta
☐ Cimzia
☐ Cosentyx
☐ Cyclosporine
☐ Cytoxan

☐ Gold
☐ Enbrel
☐ Humira
☐ Ilaris
☐ IVIG
☐ Imuran
☐ Kevzara
☐ Kineret
☐ Methotrexate
☐ Olumiant
☐ Orencia
☐ Otezla
☐ Plaquenil
☐ Remicade
☐ Rituxan
☐ Simponi
☐ Sulfasalazine
☐ Stelara

☐ Taltz
☐ Xeljanz
☐ Ambien
☐ Ativan
☐ Halcion
☐ Klonopin
☐ Lunesta
☐ Restoril
☐ Valium
☐ Xanax
☐ Celexa
☐ Desyrel
☐ Elavil
☐ Trazodone
☐ Cymbalta
☐ Lyrica
☐ Neurontin

☐ Buspr Wellbutrin
☐ Effexor Pristiq
☐ Lexapro
☐ Pamelor
☐ Paxil
☐ Prozac
☐ Savella
☐ Seroquel
☐ Zoloft
☐ Codeine
☐ Hydrocodone
☐ Lortab / Lorcet
☐ Oxycontin
☐ Percocet/ dan
☐ Tramadol
☐ Tylenol #3
☐ Ultram/Ultracet

☐ Vicodin
☐ Baclofen
☐ Flexeril
☐ Norflex
☐ Parafon forte
☐ Robaxin
☐ Skelaxin
☐ Soma
☐ Zanaflex
☐ Cholesterol/ Statins
☐ Flu vaccine
☐ Hepatitis vaccine
☐ Pneumovax
☐ Shingles vaccine
☐ Tetanus
☐ Drug study
☐ Injections (cortisone)

Have you had side effects from any of these drugs? ☐ No ☐ Yes → (which medicine / what side effect?)

Work / Lifestyle / Family / Habits / Exercise

Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed
Who lives with you?__________________________ How many Kids ?________
Do you have help at home? ☐ No ☐ Yes → Who:_______________________
Current Job? ___________________________ Employer ___________________
Do you Smoke? ☐ Never ☐No (Quit ___yrs ago) ☐Yes → (Packs per day?__)
Do you drink alcohol? ☐Never ☐I quit ☐Rarely ☐Socially ☐Daily (_________)
Have you use illegal drugs? ☐ Never ☐ Yes (Which ___________________)
Is drug/alcohol abuse a problem? ☐No ☐Yes→ ☐ For ME ☐My Family
What exercise do you do: ☐ None ☐Walk ☐Bike ☐Pool ☐Run ☐Gym
☐Cardio ☐Weights ☐Stretching ☐Yoga ☐Pilates ☐Golf

My Family History

	Mother	Father	Brother	Sister
Alive? (Y/N)				
Age				
Heart attack				
Diabetes				
Hypertension				
Stroke				
Cancer/type				
Arthritis/type				
Depression				
Emphysema				
Alzheimers				

Daily Function

ARE YOU ABLE TO (check box)	No Difficulty	Some Difficulty	Much Difficulty	Cannot Do
Dress yourself; including laces & buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire body?				
Bend down & pick up clothing from floor?				
Turn regular faucets on and off?				
Get in and out of a car?				

What else do you want Dr. Tate to know: ____

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Nurse Notes: ____

RN:_______________________________ Patient: _______________________________
RN Signature Patient Signature