Office Use only	Doctor:	LRDC Chart #:	Appointment Date:

Little Rock Diagnostic Clinic
Rheumatology - Patient Questionnaire

This information will become part of the medical record and is subject to federal privacy laws.

Full Name: _____ Date of Birth: _____

E-mail address: _____ Cell Phone: _____

Circle all that apply: tobacco use high blood pressure diabetes heart disease

Describe the medical problem or reason that you are here for evaluation today.

_____

_____

_____

_____

When did it start? _____

How long does it last? _____

Where is it located? _____

How severe is it? _____

How often does it occur? _____

Aggravated by? _____

Relieved by? _____

Vitals	This box will be completed by the nursing staff at the Provider's office Please DO NOT write.					
Ht	**WT**	**Temp**	**BP**	**Pulse**	**Resp**	**Pulse ox**

Please list the medications you are currently taking. Please include all over-the-counter and herbal medications (use back of page if needed):

Medication Name	Dosage	How often	Started	Problem medication for	Doctor who wrote

Pharmacy Name and Address _____

Do you get your medications for 30 days or 90 days at a time? (circle one) **30 days** **90 days**

Please list any drug allergies or side effects (use back page if needed)

When	Drug	Describe Reaction

Immunizations (list date of last)

Tetanus	Pneumonia	Shingles	Flu

List all the physicians that you are currently seeing:

Physician Name	Specialty	Condition being treated	Next Office Visit	Would you like a copy of your visit sent to this doctor?

Review of Systems- MEN ONLY

Please check a box below for every question that applies to your current health

General	No	Yes
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:		

Head/Neck	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:		

Respiratory	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:		

Heart	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:		

Gastrointestinal	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:		

Urinary	No	Yes
Dribbling		
Painful urination		
Blood in urine		
Excessive urination		
Slow stream		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:		

Reproductive	No	Yes
Erection problems		
Discharge from penis		
Decreased libido		
Other:		

Metabolic	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:		

Neurological	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:		

Psychiatric	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:		

Skin	No	Yes
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:		

Musculoskeletal	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:		

Blood/lymph	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:		

Immunity	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:		

Review of Systems- WOMEN ONLY

Please check a box below for every question that applies to your current health

General	No	Yes
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:		

Head/Neck	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:		

Respiratory	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:		

Heart	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:		

Gastrointestinal	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:		

Urinary	No	Yes
Painful urination		
Blood in urine		
Excessive urination		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:		

Reproductive	No	Yes
Abnormal pap smear		
Painful periods		
Painful intercourse		
Hot flashes		
Irregular periods		
Vaginal discharge		
Other:		

Skin	No	Yes
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:		

Neurological	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:		

Psychiatric	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:		

Metabolic	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:		

Musculoskeletal	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:		

Blood/lymph	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:		

Immunity	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:		

Past Medical History

Place check all that apply to you

Allergies		Blood clots		Gallbladder disease		Kidney disease	
Anemia		Cancer (type)		Heartburn/ reflux		Seizures	
Chest pains		COPD		Hepatitis C		Thyroid disease	
Anxiety		Heart Disease		High blood pressure			
Arthritis		Depression		Irritable bowel disease			
Asthma		Diabetes		Myocardial infarction			
Atrial fibrillation		Elevated lipids		Osteoporosis			

Past Surgical History

Place the Year (if known) to all that apply to you

	Year		Year	**Men Only**	Year	**Women Only**	Year
Heart Balloon		Gastric Bypass		Prostate Biopsy		Breast Implants	
Appendix Removal		Hernia Repair		Prostate Surgery		Tubal	
Knee Scope		Hip Replacement		Vasectomy		Breast Biopsy	
Back Surgery		Knee Replaced				C-section	
Blood transfusion		LASIK Eye				D&C	
Heart Bypass		ORIF				Hysterectomy	
Cardiac Pacemaker		Thyroid Removal				Mastectomy	
Carpal Tunnel		Tonsil Removal				Fibroid Removal	
Cataract Removal						Breast Reduction	
Intestine Removal						Hyst and Ovaries	
Colostomy Bag						Vaginal Hyst	

Other: _____

_____

_____

Family History

Place a check mark in the box to all that apply

___ Adopted/unknown

	Mother	Father	Sister	Brother	Other
Alive (age)					
Deceased (at what age)					
Attention Deficit Disorder					
Alcoholism					
Allergies					
Alzheimer's disease					
Arthritis					
Asthma					
Blood disorder					
Cancer					
Type of cancer					
Heart disease after 50					
Heart disease before 50					
Depression					
Developmental Problems					
Diabetes					
Skin problems					
Elevated lipids					
Genetic disease					
Hearing problems					
High blood pressure					
Irritable bowel disease					
Learning problems					
Mental illness					
Migraines					
Obesity					
Osteoporosis					
Poor circulation					
Kidney disease					
Seizures					
Stroke					
Lupus					
Thyroid disorder					

Other relevant family history:

_____

_____

_____

_____

Social History

Tobacco History:

Smoking Tobacco Use

Tobacco Type:	Use daily	Usage per day	Years used	Age started	Age stopped
☐ Cigarette	☐	____ #packs/cig			
☐ Cigarillo	☐	____ cigarillos			
☐ Cigar	☐	____ cigars			
☐ Pipe	☐	____ pipes			

Non-Smoking Tobacco Use

Tobacco Type:	Use Daily	Usage per day	Years used	Age started	Age stopped
☐ Chewing	☐	____ units			
☐ Smokeless	☐	____ units			
☐ Snuff	☐	____ units			

Have you ever tried to quit smoking? No / Yes Year quit? _____

Cessation method? _____ Longest period tobacco free? _____ Relapsed? Yes / No
If so, why?
_____
_____

Alcohol History:

No____ Yes____ Formerly (list year quit) _____
Type of alcohol _____
How frequently _____
How much a day? _____
When was your last drink? _____

Caffeine History:

Yes ___No _____ if Yes Type?_____ Servings Per Day_____

Demographics:

The Federal Government requires us to collect the following information.
This information is part of the medical record and is subject to privacy laws.

Race (must choose one):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

Ethnicity (check one) _____Hispanic _____Non-Hispanic
Primary Language Spoken:_____
Country of Birth (if not US): _____
Hand Dominance: _____Right _____Left _____Ambidextrous

Education:

Highest level of Education:_____
Any Degree obtained:_____

Employment:

Employer:_____
Occupation:_____
Employment Status:_____
If Retired, Date: _____

Military Experience:

No _____ Yes_____

Branch: _____

Years served: _____

Domestic:

Current Marital Status (circle one): Single Married Widowed Divorced

Previously widowed? ___ No ___ Yes

Previously divorced? ___ No ___ Yes

Children? ___ No ___ Yes # Sons____ # Daughters ____

Who lives with you? _____

Sleep Patterns:

Changes in sleep patterns: ___ No ___ Yes

Average number of hours of sleep per night: _____

Trouble falling asleep: ___ No ___ Yes

Difficulty staying asleep: ___ No ___ Yes

Frequent waking episodes at night: ___ No ___ Yes

Disrupted breathing, gasping, gagging or choking for air during sleep: ___ No ___ Yes

Lifestyle:

Activity level: ___Moderate ___Sedentary ___Vigorous

Health club member: ___Now ___Previously ___Never

Type of exercise: _____

Exercise frequency: _____

Hours/week: _____

Hobbies/Activities: _____

Current Diet : _____

Animals in the home: No__ Yes __ Type_____

Religious/Spiritual:

Do you have a religious affiliation? No ___ Yes ___ Religion name: _____

Home Environment/Safety:

Smoke detectors in home? No ___ Yes ___

Carbon monoxide detectors in home? No ___ Yes ___

Falls in the last year? No ___ Yes ___ Number of falls: ___

Pool/spa at home: No ___ Yes ___

Seat belt use? No ___ Yes ___

Recent Travel

Out of state? _____

Out of country? _____

Known exposure to disease? _____