Please check the appropriate items to help the doctor further clarify your arthritis problem as well as understand your general health. He or she will ask specific questions about the items checked during your appointment.

INTEGUMENTARY (Skin and/or Breast)

- ☐ Hives
- ☐ Itching
- ☐ Mole Changes
- ☐ Rash/Rashes
- ☐ Ulcer
- ☐ Nail Problems
- ☐ Hair Loss
- ☐ Nodules/Bumps
- ☐ Sun Sensitivity
- ☐ Psoriasis
- ☐ Sores
- ☐ Skin Tightness
- ☐ Color changes of hands or feet in the cold
- ☐ Easy Bruising

CONSTITUTIONAL

- ☐ Recent weight gain (Amount ________)
- ☐ Recent weight loss (Amount ________)
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Chills

EYES, EARS, NOSE AND THROAT (HEENT)

- ☐ Bleeding Gums
- ☐ Difficulty in swallowing (dysphagia)
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Nose bleeds (epistaxis)
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Mouth ulcers (sores on mouth)
- ☐ Ringing in ears
- ☐ Snoring
- ☐ Changes in vision
- ☐ Visual loss
- ☐ Dental Problems
- ☐ Dryness of Mouth
- ☐ Dry eye(s) - (Feels like something in the eyes)

MUSCULOSKELETAL

- ☐ Body Pain
- ☐ Body Aches
- ☐ Calf Tenderness
- ☐ Joint Swelling
- ☐ Limited Joint Motion
- ☐ Joint Pain
- ☐ Morning Stiffness Lasting how long? _____ min. _____ hours
- ☐ Muscle Weakness
- ☐ Muscle Tenderness

RESPIRATORY

- ☐ Cough
- ☐ Wheezing (asthma)
- ☐ Shortness of breath (dyspnea)
- ☐ Coughing of blood (hemoptysis)
- ☐ Known tuberculosis exposure
- ☐ Swollen legs or feet
- ☐ Pleurisy

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Swelling of Limb (edema)
- ☐ Palpitations (irregular heart beat or sudden changes in heart beat)
- ☐ Syncope (sudden loss of consciousness)
- ☐ High Blood Pressure
- ☐ Leg Pain or Swelling

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn (stomach pain relieved by food or milk)
- ☐ Vomiting Blood (Hematemesis)
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Blood in stool (Red or black stool)
- ☐ Food Allergies
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Colitis

GENITOURINARY

- ☐ Burning on Urination (dysuria)
- ☐ Difficult or Painful Urination
- ☐ Urinary Frequency
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Urinary Incontinence
- ☐ Rash/Ulcers
- ☐ Blood in Urine (hematuria)

REPRODUCTIVE (Female)

- ☐ History of Recurrent Miscarriages
- ☐ Abnormal PAP
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Dyspareunia (Painful Sexual intercourse)
- ☐ Painful Uterine Bleeding (Dysmenorrhea)
- ☐ Hot Flashes
- ☐ Vaginal Discharge
- ☐ Menorrhagia (abnormal vaginal bleeding)

REPRODUCTIVE (Male)

- ☐ Erectile Dysfunction
- ☐ Genital Lesions
- ☐ Penile Discharge
- ☐ Testicular Mass

METABOLIC / ENDOCTINE

- ☐ Goiter
- ☐ Swollen Glands
- ☐ Uncontrolled Hunger
- ☐ Increased Thirst

EMOTIONAL

- ☐ Anxiety
- ☐ Insomnia
- ☐ Depression

IMMUNOLOGIC

- ☐ Environmental Allergies
- ☐ Hay Fever
- ☐ Food Allergies

HEMATOLOGIC / LYMPHATIC

- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Blood Clots
- ☐ Swollen Glands
- ☐ Nodules
- ☐ Transfusions (Year__________)

NEUROLOGICAL

- ☐ Dizziness
- ☐ Focal Weakness
- ☐ Gait Disturbance
- ☐ Headache
- ☐ Memory Loss
- ☐ Nervousness
- ☐ Paralysis
- ☐ Seizures
- ☐ Change in sensation with tingling, pricking or numbness of the skin or limb (paresthesia)

Date: ______________________________

MRN: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

26732 Crown Valley Pkwy, Suite 151
Mission Viejo, CA 92691
949-364-7246
Fax 949-364-1647

INITIAL HEALTH QUESTIONNAIRE

MEDICATIONS (list all, including vitamins):

____

____

____

____

ALLERGIES (medications, food and environmental):

____

____

____

CHRONIC MEDICAL ILLNESSES (please also list those being followed by other physicians):

____

____

____

SURGERIES (list all):

____

____

____

FAMILY HISTORY (list all arthritis in the family and types if known): ☐ Adopted

Grandfather:	☐ Alive	☐ Deceased	☐ Age ________	Health Problems ________________
Grandmother:	☐ Alive	☐ Deceased	☐ Age ________	Health Problems ________________
Father:	☐ Alive	☐ Deceased	☐ Age ________	Health Problems ________________
Mother:	☐ Alive	☐ Deceased	☐ Age ________	Health Problems ________________

Brothers & Sisters (Indicate "Healthy" or list health problems)

____

____

PREGNANCIES (list number): Pregnancies_____ Miscarriages_____ Abortions_____ Stillborn_____

CHILDREN: Number:_________ Illnesses ______________________________

____

SOCIAL HISTORY

City or Country of Origin:______________________ Current City: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: __________________ Smoking History: ______________ Alcohol Intake: ___________

Hobbies / Athletics: __________________________ Pets: ______________________________

Patient Signature: ______________________________

PAST MEDICAL HISTORY

Date: ______________________________

MRN: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Mission Heritage
Medical Group

We are going electronic!

Please help us out by providing us with the following information:

Name ____

Pharmacy Name ____

Pharmacy Phone Number ____

Pharmacy Address ____

City ____

Your allergies and reaction:

____

____

____

Medications **prescribed to you by your Rheumatologist only** include strength and how many times a day/week you take:

____

____

____

____

____

____

____

____

Mission Heritage
Medical Group

PHARMACY INFORMATION