PEDIATRIC RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

PATIENT NAME: ___________________________  DOB: ___________________________

ALLERGIES:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>Type of Reaction</th>
<th>FOOD</th>
<th>Type of Reaction</th>
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PETS: ______________________________________

TRAVEL: in the last year, with dates of travel

   Out of the Country? _________________________________________

   Out of the State? _________________________________________

MEDICATIONS: name and dosage

Currently taking

1. ___________________________

2. ___________________________

3. ___________________________

4. ___________________________

5. ___________________________

Taken within the last 4 months

1. ___________________________

2. ___________________________

3. ___________________________

4. ___________________________

5. ___________________________
### Past Medical History:

<table>
<thead>
<tr>
<th>Other Medical Diagnosis</th>
<th>Date</th>
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<tr>
<th>Surgery</th>
<th>Date</th>
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<th>Hospitalization</th>
<th>Date</th>
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### Family History:

Please circle if alive and well, if deceased write what age and cause of death

<table>
<thead>
<tr>
<th>M</th>
<th>MGM</th>
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<table>
<thead>
<tr>
<th>F</th>
<th>MGF</th>
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<tbody>
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<table>
<thead>
<tr>
<th>B (how many)</th>
<th>PGM</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>S (how many)</th>
<th>PGF</th>
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Please specify

- M (mother)
- F (father)
- B (brother)
- S (sister)

- MGM (maternal grandmother)
- MGF (maternal grandfather)
- PGM (paternal grandmother)
- PGF (paternal grandfather)
- C (cousin)
- MA (maternal aunt)
- MU (maternal uncle)
- PA (paternal aunt)
- PU (paternal uncle)

- Rheumatoid Arthritis
- Other Arthritis
- Ankylosing Spondylitis
- Back Pain
- Psoriasis
- Systemic Lupus Erythematosus
- Raynaud’s Disease
- Vasculitis
- Scleroderma
- Dermatomyositis
- Sjogren’s Syndrome
- Fibromyalgia/Chronic Fatigue
- Sarcoidosis
- Recurrent Fever
- Recurrent Miscarriages
- Crohn’s / Ulcerative Colitis
- Celiac Disease
- Irritable Bowel
- Thyroid Disease
- Headache/Migraine
- High Blood Pressure
- Stroke
- Heart Attack
- Heart Disease
- Depression
- Bipolar/psychiatric dis
- Cancer (type)
- Other
What is the REASON for today's visit?

REVIEW OF SYSTEMS:

Has your child had any of the following symptoms recently?

_____ Unexpected weight gain or loss (amount)________
_____ Fever
_____ Tiredness
_____ Red eyes
_____ Dry eyes or mouth
_____ Anorexia
_____ Sore throat
_____ Mouth sores
_____ Swollen glands
_____ Chest pain
_____ Palpitation/fast heart beat
_____ Heart murmur
_____ Shortness of breath
_____ Cough
_____ Wheezing
_____ Difficulty or pain when swallowing
_____ Stomach pain
_____ Diarrhea
_____ Nausea
_____ Vomiting
_____ Blood in the urine
_____ Menstrual abnormality

_____ Sun sensitivity
_____ Cold intolerance
_____ Numbness or tingling (where)
_____ Skin rash
_____ Hair loss
_____ Joint pain
_____ Joint swelling
_____ Muscle pain
_____ Muscle weakness
_____ Limp or difficulty walking
_____ Back pain
_____ Pallor or anemia
_____ Bruising or bleeding
_____ Dizziness
_____ Headache
_____ Sleep problem
_____ Moody or tearful
_____ Excessive worries
_____ Depression
_____ Decreased school performance
_____ Difficulty concentrating/poor memory
_____ Frequent school absences

HOUSEHOLD COMPOSITION: List the AGES of all people living with your child at home

<table>
<thead>
<tr>
<th>father/step (mother2)</th>
<th>mother/step (father2)</th>
<th>patient</th>
<th>brother/sister (half)</th>
<th>br/sis (half)</th>
<th>br/sis (half)</th>
</tr>
</thead>
</table>

Father's occupation:________________________________________________________

Mother's occupation:________________________________________________________

Patient's school and grade:__________________________________________________ Smoking: Y N