

Tulsa Bone & Joint Rheumatology Questionnaire  
Please fill out ALL information to the best of your knowledge

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 WHO REFERRED YOU TO US? \_\_\_\_\_  
 PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
 BRIEF SUMMARY OF THE REASON FOR YOUR VISIT: \_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY:** Place an **X** by those that apply:

- |                          |                              |                           |
|--------------------------|------------------------------|---------------------------|
| <input type="checkbox"/> | Asthma                       | OTHER MEDICAL OR SURGICAL |
| <input type="checkbox"/> | High Blood Pressure          | HISTORY : _____           |
| <input type="checkbox"/> | Diabetes                     | _____                     |
| <input type="checkbox"/> | Stomach Ulcers               | _____                     |
| <input type="checkbox"/> | Reflux Esophogitis           | _____                     |
| <input type="checkbox"/> | Low Thyroid                  | _____                     |
| <input type="checkbox"/> | Cancer (please specify type) | _____                     |
| <input type="checkbox"/> | Depression                   | _____                     |
| <input type="checkbox"/> | Appendectomy                 | _____                     |
| <input type="checkbox"/> | Coronary Bypass              | _____                     |
| <input type="checkbox"/> | Gallbladder                  | _____                     |
| <input type="checkbox"/> | Hysterectomy                 | _____                     |
| <input type="checkbox"/> | Pacemaker                    | _____                     |

**SYSTEMS REVIEW:** Please circle any of the following symptoms you've had in the last few months:

- GENERAL:      • Weight loss (not from dieting)      • Fatigue      • Fever  
 GI:              • Abdominal Pain      • Reflux      • Food sticking in esophagus  
 SKIN:            • Facial Rash      • Rash caused by sunlight  
 PULMONARY: • Pain with breathing      • Shortness of Breath      • Coughing up Blood  
 CARDIOVASCULAR: • Chest Pain      • Raynauds (blue/white hand color in cold)  
 NEUROLOGIC: • Severe Headaches      • Seizures      • Peripheral Neuropathy  
 ENT:             • Sores in nose/mouth      • Bloody sinus drainage  
 EYES:            • Excessive Dryness      • Painful red Eye  
 ID:                • Recent Infections      • History of Positive TB skin test  
 PSYCH:          • Depression      • Anxiety  
 GENITOURINARY: • Blood in Urine      • History of miscarriages

Name of Your Employer: \_\_\_\_\_

Describe Your Specific Job: \_\_\_\_\_

Do You Smoke? Circle One: NO    QUIT    YES (packs per day?) \_\_\_\_\_

Do you drink alcohol?              NO    QUIT    YES (drinks per week?): \_\_\_\_\_

MARITAL STATUS: Circle one: Married    Widowed    Divorced    Single

FAMILY HISTORY: Circle any: Arthritis    Lupus    Osteoporosis

Other: \_\_\_\_\_

Rheumatology Health Questionnaire (Continued)

**DRUG ALLERGIES** (include type of reaction):

---

---

---

**CURRENT MEDICATIONS** (Include the dose if possible):

*Example: Motrin 600mg 3 times daily*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_

**Pain Numeric Rating Scale**

1. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate you pain **RIGHT NOW**?

0      1      2      3      4      5      6      7      8      9      10  
**No Pain** **Worst Pain**

2. On the same scale, how would you rate your **WORST** pain during the last week?

0      1      2      3      4      5      6      7      8      9      10  
**No Pain** **Worst Pain**