

PEDIATRIC

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 HISTORY: _____ |
| <input type="checkbox"/> | Anemia | _____ |
| <input type="checkbox"/> | Diabetes | _____ |
| <input type="checkbox"/> | Stomach Ulcers | _____ |
| <input type="checkbox"/> | Frequent Colds | _____ |
| <input type="checkbox"/> | Low Thyroid | _____ |
| <input type="checkbox"/> | Cancer (please specify type) | _____ |
| <input type="checkbox"/> | Depression | _____ |
| <input type="checkbox"/> | Appendectomy | _____ |
| <input type="checkbox"/> | Constipation | _____ |
| <input type="checkbox"/> | Gallbladder | _____ |
| <input type="checkbox"/> | Rheumatic Fever | _____ |
| <input type="checkbox"/> | Vision Problems | _____ |

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

Birth Weight: _____ Birth Length: _____

Were there any concerns about growth or progress made in areas such as rolling over, sitting, walking, ability to ride a tricycle, dress self and feed self? _____

If yes, please describe: _____

Are there concerns about language or speech development? _____

If yes, please describe: _____

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. _____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOUR ARTHRITIS MAKES YOU FEEL



0
No Hurt



1
Hurts
Little Bit



2
Hurts
Little More



3
Hurts
Even More



4
Hurts
Whole Lot



5
Hurts
Worst