UCLA Health System

NEW PATIENT QUESTIONNAIRE

UCLA Department of Medicine
Rheumatology

MRN:
Patient Name:

(Patient Label)

Answering the following questions will help your doctor provide the best care for you. Please take the time to complete this survey before you see the doctor.

- * Have you had arthritis or rheumatism for more than 3 months?........................... ☐ No ☐ Yes
- Have you ever had joint stiffness in the morning lasting at least one hour for more than 6 weeks?.. ☐ No ☐ Yes
- * Have you ever had nodules or bumps under the skin around the elbow or ankle? ☐ No ☐ Yes
- * Have you ever had swelling in any of the following joints (lasting more than 6 weeks)?

	Left		Right	
a) wrist………………………………………………….	☐ No	☐ Yes	☐ No	☐ Yes
b) finger (but not the joints nearest the fingernails)	☐ No	☐ Yes	☐ No	☐ Yes
c) elbow………………………………………………..	☐ No	☐ Yes	☐ No	☐ Yes
d) knee…………………………………………………	☐ No	☐ Yes	☐ No	☐ Yes

Review of Symptoms Checklist (check all the symptoms that apply to you)

General:

- ☐ Feeling ill
- ☐ Fatigued
- ☐ Fever
- ☐ Shaking Chills
- ☐ Back pain
- ☐ Drenching night sweats
- ☐ Decreased appetite
- ☐ Weight loss
  (How many pounds ______?
  Over how many months ____?

Head and Neck:

- ☐ Headaches
- ☐ Scalp pain
- ☐ Jaw pain with chewing or eating
- ☐ Rapid loss of lots of hair
- ☐ Multiple episodes of sinusitis
- ☐ Neck pain

Eyes:

- ☐ Gritty or sandy feeling in your eyes
- ☐ History of eye inflammation (redness or pain) requiring medical treatment
- ☐ Dry eyes

Skin:

- ☐ Rash on your cheeks for more than a month
- ☐ Psoriasis (scaly patches)
- ☐ Other types of rash (describe)
- ☐ Skin break out (rash) after being in the sun (not a sunburn)
- ☐ Puffy swollen fingers for more than a month
- ☐ Skin thickening or tightening of the fingers or toes
- ☐ Skin thickening or tightening of arms, legs, face, neck or trunk
- ☐ Sores leaving scars in the fingertips

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Review of Symptoms Checklist (check all the symptoms that apply to you)

Mouth:

- ☐ Sores in mouth or nose for more than 2 weeks at a time
- ☐ Dry mouth awakening you and requiring a drink of water
- ☐ Other dry mouth

Circulation:

- ☐ Fingers unusually sensitive to the cold
- ☐ Fingers change color in the cold (circle all colors that apply) White Blue Purple Red
- ☐ Blood clot in lungs, legs or other areas (please circle body part)

Chest Heart and lung Symptoms:

- ☐ Pleurisy or chest pain made worse by deep breathing for more than a few days
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Breathing difficulty with exercise
- ☐ Palpitations
- ☐ Asthma or wheezing
- ☐ Cough

With…	No	Yes
Sputum?	☐	☐
Blood?	☐	☐

	No	Yes	
Do you know anyone with tuberculosis (TB) needs?	☐	☐	When? .
Have you ever had tuberculosis (TB)?	☐	☐	When?
Have you ever had tuberculosis (TB) skin test (PPD)?	☐	☐	Results Pos. ☐ Neg. ☐

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Ulcer
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in your stool

Infections:

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Frequent or recurrent infections
- ☐ HIV or AIDS

Travel History:

- ☐ US travel in last 5 years? (Where? ______________________________)
- ☐ Out of country travel? (Where? ______________________________)

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Genito-urinary:
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Ulcers on vagina, penis, or scrotum
- ☐ Discharge from vagina or penis
- ☐ Sexually transmitted disease

(MALE ONLY)
- ☐ Prostate disease

Reproductive history:
- ☐ Infertility

(FEMALE ONLY)
- ☐ Miscarriages
- ☐ Menstrual cycle irregularities
- ☐ Menopause

Muscular:
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Muscle weakness for more than 3 months
- ☐ Weakness combing your hair for more than 3 months
- ☐ Weakness rising from a sitting position for more than 3 months

Neurologic:
- ☐ Stroke
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Seizure, convulsion or fit

Sleep problems:
- ☐ Sleep apnea
- ☐ Insomnia
- ☐ Daytime drowsiness

Psychiatric:
- ☐ Anxiety
- ☐ Depression

Endocrine:
- ☐ Adrenal disease
- ☐ Diabetes
- ☐ Heat or cold intolerance
- ☐ Thyroid disease

Hematologic:
- ☐ Easy bruising
- ☐ Lymphoma
- ☐ Swollen gland

Allergic/Immunologic:
- ☐ Hives

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ADDITIONAL MEDICAL QUESTIONS

*Have you had a blood test for rheumatoid arthritis? ………………………… ☐ No ☐ Yes

If YES, was the result ☐ negative? ☐ positive? ☐ don't know

*Have you had a blood test for lupus?
(e.g. antinuclear antibody, ANA, FANA or LE prep) ………………………… ☐ No ☐ Yes

If YES, was the result: ☐ negative? ☐ positive? ☐ don't know

*Have you ever been told by a doctor that you had:	No	Yes
Anemia?	☐	☐
Low white cell count?	☐	☐
Low platelet count?	☐	☐
Protein in your urine?	☐	☐
Discoid lupus?	☐	☐
Pulmonary fibrosis (scarring of the lungs)	☐	☐
High CPK (muscle enzyme)?	☐	☐

SOCIAL HISTORY

*Regarding relationships, are you? (check one) ☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Widowed ☐ Other __________

*Have you had children? ☐ No ☐ Yes If Yes, how many? Son(s) ___ Daughter(s) ____

*Do you live? (check one) ☐ With Spouse/ Partner ☐ With family ☐ With friend(s) ☐ Alone

*Do you smoke? ☐ Never ☐ Currently ☐ Previously

*Started smoking at what age? _________ (OR) what year? _______

*Quit smoking at what age? _________ (OR) what year? _______

*Do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Less Frequently

*What do/did you drink? and # of drinks?
☐ Beer (# ____ per day or # per week ____)
☐ Wine (# ____ per day or # per week ____)
☐ Liquor (# ____ per day or # per week ____)

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OCCUPATIONAL HISTORY

*About your work, are you? ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled

*What is/was your main job? ______________________

*How many years in this job? ______________________

*When did you quit/retire (if applicable)? ______________________

*Was there a medical reason for quitting work? ☐ No ☐ Yes If Yes, specify: ______________

FAMILY HISTORY (Please check all that apply)

	Father	Mother	Brother(s)	Sister(s)	Child	Aunt	Uncle
Rheumatoid Arthritis …………..	☐	☐	☐	☐	☐	☐	☐
Osteo–Arthritis (or) Degenerative Arthritis …………	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE) ……………………	☐	☐	☐	☐	☐	☐	☐
Osteoporosis ……..…………..	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis ………………	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease ……………….	☐	☐	☐	☐	☐	☐	☐
Diabetes ………………………..	☐	☐	☐	☐	☐	☐	☐
Cardiovascular Disease ………	☐	☐	☐	☐	☐	☐	☐
Other Major Medical Problem ..	☐	☐	☐	☐	☐	☐	☐
______________________	☐	☐	☐	☐	☐	☐	☐
______________________	☐	☐	☐	☐	☐	☐	☐
______________________	☐	☐	☐	☐	☐	☐	☐

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Health Assessment Questionnaire

Please check the response which best describes your usual abilities **(over the past week)**

At this moment are you able to:		Without any difficulty	With some difficulty	With much difficulty	Unable to do
Dressing/ Grooming	**Are you able to:**				
	1. Dress yourself, including tying shoelaces and doing buttons? …………	☐	☐	☐	☐
	2. Shampoo your hair ……………………..	☐	☐	☐	☐
Arising	**Are you able to:**				
	1. Stand up from an armless straight chair?	☐	☐	☐	☐
	2. Get in and out of bed? ………………….	☐	☐	☐	☐
Eating	**Are you able to:**				
	1. Cut your meat? …………………………..	☐	☐	☐	☐
	2. Lift a full cup or glass to your mouth? …	☐	☐	☐	☐
	3. Open a new carton of milk? …………….	☐	☐	☐	☐
Walking	**Are you able to:**				
	1. Walk outdoors on flat ground? …………	☐	☐	☐	☐
	2. Climb up 5 steps? ………………………..	☐	☐	☐	☐
Hygiene	**Are you able to:**				
	1. Wash and dry your entire body? ………..	☐	☐	☐	☐
	2. Take a tub bath? ………………………….	☐	☐	☐	☐
	3. Get on and off the toilet? ………………...	☐	☐	☐	☐

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At this moment are you able to:		Without any difficulty	With some difficulty	With much difficulty	Unable to do
Reach	**Are you able to:**				
	1. Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
	2. Bend down and pick up clothing from the floor?	☐	☐	☐	☐
Grip	**Are you able to:**				
	1. Open car doors?	☐	☐	☐	☐
	2. Open jars which have previously been opened?	☐	☐	☐	☐
	3. Turn regular taps on and off?	☐	☐	☐	☐
Activities	**Are you able to:**				
	1. Run errands and shop?	☐	☐	☐	☐
	2. Get in and out of a car?	☐	☐	☐	☐
	3. Do chores such as vacuuming or yardwork?	☐	☐	☐	☐

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Health Assessment Questionnaire

Please check any AIDS OR DEVICES that you usually use for any of these activities

- ☐ Raised Toilet Seat
- ☐ Bathtub Seat
- ☐ Jar Opener (for jars previously opened)
- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Other (Specify: ____________________
- ☐ Bathtub Bar
- ☐ Long-handled appliances for reach
- ☐ Long-handled appliances in bathroom
- ☐ Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
- ☐ Built up or special utensils
- ☐ Special or built up chair

Please check any categories for which you usually need HELP FROM ANOTHER PERSON

- ☐ Dressing
- ☐ Arising
- ☐ Eating
- ☐ Walking
- ☐ Hygiene
- ☐ Reach
- ☐ Gripping
- ☐ Activities

MD initials ______