RHEUMATOLOGY OF THE WOODLANDS NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____

What is your principal reason for seeing the doctor today? _____

_____

How long have you had this problem? _____

What studies have been done? _____

Who is your referring doctor? _____ Primary care doctor? _____

List current and past conditions:	Date	List surgeries:	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion? _____ If so, when? _____

Current medications with dosage/milligrams:

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

MEDICATION ALLERGIES: _____

Family Medical History

Father	Age _____	Conditions: _____
Mother	Age _____	Conditions: _____
Brothers	Age _____	Conditions: _____
Sisters	Age _____	Conditions: _____
Children	Age _____	Conditions: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Domestic Partner _____

Occupation _____ Number of hours worked per week? _____

Tobacco: Cigarettes _____ Cigars _____ Pipe _____ Smokeless _____ Past tobacco use? _____

Alcohol: _____ How many drinks per day: _____ Week? _____ How long? _____

Do you consume caffeine? Coffee ____ Soda ____ Chocolate ____ Tea ____ Tablets ____ Energy drinks _____

Have you ever or are you currently using illicit drugs? Yes _____ No _____

Please provider your preferred pharmacy and address. _____

_____

Please provide your preferred mail order / specialty pharmacy and address. _____

_____