

Affix Label Here

NEW PATIENT INFORMATION SHEET

Date: _____

Why are you seeing the Doctor today? _____

What is your marital status (circle)? Single Married Common-law Widowed Divorced Separated

What is your age? _____

How many children do you have? _____

What is your Occupation? _____

Are you on Disability? YES NO

What is your Drug Plan: Private Insurance Over 65 Government Ontario Drug Benefits Other

Do you **SMOKE** cigarettes?

Never Used to, but quit Yes, still do

a. Number of years smoked: _____

b. Number of packs smoked per day: _____

Do you drink Alcohol?

Never Yes

a. Number of drinks per week: _____

Past Medical History

1. Do you have or have you had any of the following illnesses?

- a. High blood pressure
- b. High cholesterol
- c. Diabetes
- d. Heart disease
- e. Stomach ulcer
- f. Osteoporosis
- g. Depression
- h. Cancer

a. Type: _____

2. Please list any additional Medical Conditions that you have been diagnosed with:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____
- g. _____

3. Please list any surgeries that you have had:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____

4. Please list any prescription and non-prescription **MEDICATIONS** you are taking now:

Medication Name	Dose/Amount	How Often

What NSAIDs have you tried?

- Celebrex
- Naprosyn
- Advil/Motrin
- Arthrotec
- Indocid
- Mobicox
- Diclofenac
- Voltaren

5. Do you have any ALLERGIES to Medications? YES NO

a. If YES, please list the medication and describe what happens?

i. _____

ii. _____

iii. _____

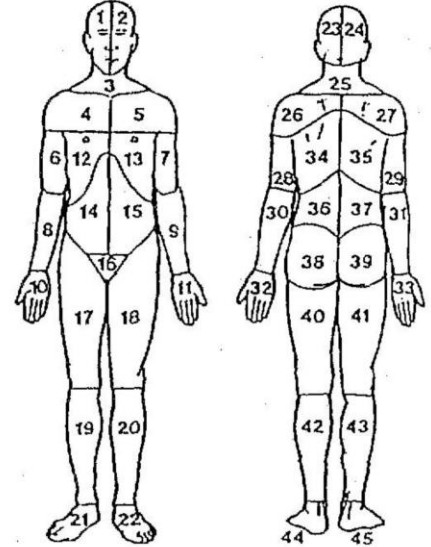
6. Do any of your immediate family or distant family relatives have any of the following?

- Arthritis – Unsure of type
- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Lupus
- Scleroderma
- Raynaud's Phenomenon
- Blood Clots
- Psoriasis
- Psoriatic Arthritis
- Ankylosing Spondylitis
- Inflammatory Bowel Disease
- Uveitis
- Cancer
- Lymphoma
- Multiple sclerosis

7. If known, please indicate when you last had screening for the following cancers.

- Colon Year: _____
- Lung Year: _____
- Breast Year: _____
- Cervical Year: _____
- Prostate Year: _____

8. Please shade in the following diagram to show where you have had pain over the past month.



Thank-You for completing the questionnaire, DO NOT WRITE BELOW THIS LINE

History of Presenting Illness

Review of Systems (Address appropriate sections as per patient):

General:

Inflammatory arthritis	Yes / No
Chest pain	Yes / No
Shortness of breath	Yes / No
Skin rash	Yes / No
Fatigue	Yes / No
Fevers/chills	Yes / No
Night sweats	Yes / No
Weight loss of >10%	Yes / No
Abdominal symptoms	Yes / No

Connective tissue disease:

Raynaud's phenomenon	Yes / No
Dry eyes/mouth	Yes / No
Mucosal ulcers	Yes / No
Alopecia	Yes / No
Photosensitivity	Yes / No
Hives	Yes / No
Skin ulcers	Yes / No
Skin tightening	Yes / No
GERD	Yes / No
Dysphagia	Yes / No
Muscle weakness	Yes / No
Thrombosis	Yes / No

Other:

Frequent infections:

Recent hospital admissions:

Cardiovascular risk assessment:

Vaccines UTD:

Spondyloarthropathy:

Psoriasis/nail changes	Yes / No
Inflammatory back pain	Yes / No
Inflammatory bowel disease	Yes / No
Inflammatory eye symptoms	Yes / No
Dactylitis	Yes / No
Enthesitis	Yes / No

Vasculitis:

Purpura/petechiae	Yes / No
Skin ulcers/gangrene	Yes / No
Genitourinary ulcers	Yes / No
Post-prandial pain/Bloody stools	Yes / No
Vision change/loss	Yes / No
Inflammatory eye symptoms	Yes / No
Orbital swelling/proptosis	Yes / No
Nasal discharge/sinusitis	Yes / No
Hearing loss	Yes / No
Headache	Yes / No
Confusion	Yes / No
Seizures	Yes / No
Peripheral numbness/weakness	Yes / No

Previous Investigations

(i.e. bloodwork, imaging, BMD)

Previous Treatments for Rheum Issue

(i.e. corticosteroids – how long/often)

Physical Examination

VITALS

Pulse _____ BP (R) _____ BP(L) _____ Height _____ Weight _____ Temp _____

H&N (inspection of hair & scalp, eyes, mouth, thyroid)

Normal ___ Comment: _____

Abnormal ___

LYMPH NODES (palpation)

Normal ___ Comment: _____

Abnormal ___

SKIN & NAILS (inspection for thickening, rashes, nodules, telangiectasia, livedo, vasculitic changes)

Normal ___ Comment: _____

Abnormal ___

CVS (heart sounds, murmurs, rhythm, edema, peripheral vascular exam)

Normal ___ Comment: _____

Abnormal ___

CHEST (auscultation, percussion)

Normal ___ Comment: _____

Abnormal ___

ABD (auscultation, palpation, percussion)

Normal ___ Comment: _____

Abnormal ___

MSK (inspection, range of motion)

Normal ___ Comment: _____

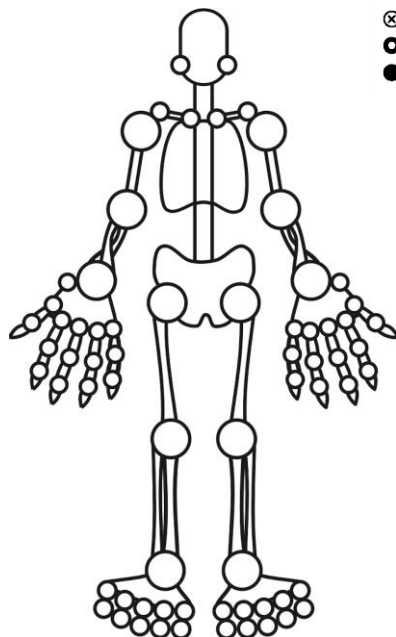
Abnormal ___

NEURO (if relevant):

(strength, reflexes, sensation)

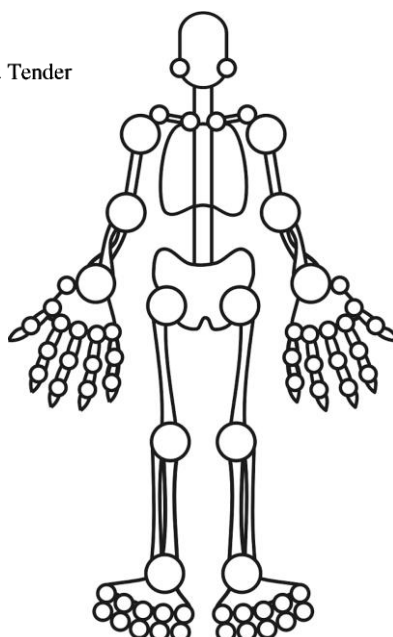
Normal ___ Comment: _____

Abnormal ___

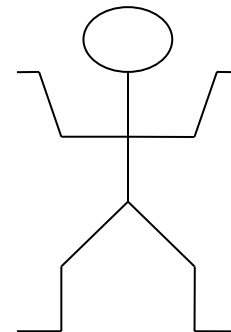


TRAINEE

- ⊗ Tender
- Swollen
- Swollen & Tender



CONSULTANT



Spondyloarthritis (if relevant):

Schober's test: _____ cm of expansion

Chest Expansion _____ cm

Occiput-Wall Distance _____ cm

IMPRESSION

PLAN

Cancer screening: Reviewed

Vaccinations: Flu Pneumo Shingles