KAISER PERMANENTE®

Rheumatology:
Patient questionnaire

Please fill out this form and give it to the specialist you will be seeing today.

What is the most important problem we can help you with today? _____

_____

_____

_____

_____

Personal History

Please check the boxes below if you have had any of the following symptoms or conditions - either in the last 30 days or in the past. Check all that apply

General			**Head, eyes, ears, nose, and throat**	
Past	Present		Past	Present
☐	☐	Anxiety, nervousness	☐	☐ Double vision
☐	☐	Depression	☐	☐ Blindness
☐	☐	Recent weight gain	☐	☐ Dryness of mouth or eyes
☐	☐	Recent weight loss	☐	☐ Felt like something is in your eye
☐	☐	Fever	☐	☐ Mouth sores
☐	☐	Chills	☐	☐ Trouble tasting
☐	☐	Fatigue (feeling tired or weak)	☐	☐ Sinus trouble
☐	☐	Alcohol use problem		
☐	☐	Cancer		
Nervous system			**Bladder and kidneys**	
Past	Present		Past	Present
☐	☐	Dizziness	☐	☐ Blood in urine
☐	☐	Falls that cause injury	☐	☐ Burning during urination
☐	☐	Fainting	☐	☐ Frequent night time urination
☐	☐	Memory loss	☐	☐ Slow or weak stream
☐	☐	Numbness/tingling	☐	☐ Kidney stones
☐	☐	Carpal tunnel syndrome		
☐	☐	Headaches or migraines		
☐	☐	Stroke		
Heart and circulation			**Stomach and intestines**	
Past	Present		Past	Present
☐	☐	Shortness of breath when lying flat	☐	☐ Abdominal pain
☐	☐	Pain in chest	☐	☐ Heartburn
☐	☐	Irregular heartbeat	☐	☐ Nausea, vomiting
☐	☐	Swollen legs, ankles, or feet	☐	☐ Vomiting blood
☐	☐	Blood clot in the leg (phlebitis)	☐	☐ Trouble swallowing
Lungs			☐	☐ Diarrhea
Past	Present		☐	☐ Constipation
		Shortness of breath after:	☐	☐ Black tarry stools
☐	☐	– walking 1 to 2 blocks	☐	☐ Loss of appetite
☐	☐	– after walking 1 flight of stairs	☐	☐ Ulcer
☐	☐	Cough	☐	☐ Irritable bowel syndrome
☐	☐	Asthma (wheezing)	☐	☐ Diverticulitis
☐	☐	Pain on taking deep breath	☐	☐ Hepatitis
☐	☐	Coughing up blood		
☐	☐	Blood clot in lung (pulmonary embolus)		
☐	☐	Tuberculosis		

Continued on back page

Skin			Blood	
Past	Present		Past	Present	
☐	☐	Rash	☐	☐	Bleeding problems
☐	☐	Welts	☐	☐	Anemia (low red blood cells)
☐	☐	Itching			
☐	☐	Rash over nose and cheeks			
☐	☐	Patchy or total hair loss			
☐	☐	Hands turn blue, white, or red in cold			
☐	☐	Tight skin			
☐	☐	Finger ulcer			
☐	☐	Psoriasis			
☐	☐	Sick when in the sun			

Habits and lifestyle

Occupation (if you're retired, list your previous occupation): _____

How much of the following do you usually drink?

		Day	Week
Glasses of wine or bottles of beer _____	per	☐	☐
Ounces of hard liquor _____	per	☐	☐

If you used to drink alcoholic beverages but quit, give approximate date you stopped drinking: _____

List any regular physical exercise and activities you do and how often you do them:

Type of exercise or activity	Times per week
_____	_____
_____	_____