SANTIONI RHEUMATOLOGY
821 S MAIN STREET, SUITE 3
OLD FORGE, PA 18518
570-457-0562 Fax 570-457-0603

LAST NAME_____ FIRST NAME_____ MI_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME PHONE_____ CELL_____ MALE_____ FEMALE_____
DATE OF BIRTH_____ LAST FOUR SS#_____ MARITAL STATUS_____

INSURANCE	**PRIMARY**	**SECONDARY**
NAME	_____	_____
ID	_____	_____
GROUP#	_____	_____
SUBSCRIBER/DOB	_____	_____
EFFECTIVE DATE	_____	_____

RHEUMATOLOGY QUESTIONNAIRE (for patient to complete and bring to appointment)

The name of the physician providing your primary medical care_____
Reason for your visit_____
_____
When did you first notice this problem? Month _____ Year _____
Have you had x-rays, CT, MRI for this problem? ⬜ Yes ⬜ No If yes, where did you go for them? _____
Please list the names of other practitioners you have seen for this problem: _____
_____
Please list any previous treatments (such as physical therapy, medications) for this problem:_____
_____
Please list all of the DRUGS or MEDICATIONS you are taking (including aspirin, any drug you purchased without a prescription or birth control pills)

	Name of Medication	Dose	How many a day		Name of Medication	Dose	How many a day
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

Are you allergic to any medications? ⬜ Yes ⬜ No If Yes, please list which ones:
_____
List any vitamins or herbal remedies you are using:_____
Please list all of your previous hospitalizations and surgeries below:

	Condition of Procedure	Year		Condition of Procedure	Year
1			6		
2			7		
3			8		
4			9		
5			10		

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Please **CHECK BOX** if you have ever been diagnosed with or had any of the following conditions:

Cataract		Stomach/duodenal ulcer		Meningitis	
Glaucoma		Liver cirrhosis		Stroke/paralysis	
Uveitis or Iritis		Hepatitis		Seizures/epilepsy	
Migraine Headaches		Gallstones		Depression	
Sinus Infections		Pancreatic Disease		Nervous Breakdown	
		Intestinal polyp			
Rheumatic Fever		Esophageal reflux		Anemia	
Heart Attack/myocardial infarct		Other esophageal disease		Blood Transfusion	
Heart failure		Colitis		If yes, what year?	
Arrhythmia		Diverticulitis		Tattoos	
High Blood Pressure		Irritable bowel syndrome		Blood clot in leg	
Heart Murmur					
		Kidney stones		Cancer	
Asthma		Nephritis		Type	
Pneumonia		Kidney Infection		Alcoholism	
Pleurisy		Syphilis		Drug Abuse	
Blood clot in the lung		Gonorrhea		HIV testing	
Tuberculosis		Chlamydia		OTHER CONDITIONS	
Positive TB skin test					
Emphysema		Rheumatoid arthritis		WOMEN ONLY	
Chronic Bronchitis		Gout		Pregnancies	
		Lupus		If yes, how many?	
Skin ulcers lower leg		Serious joint injury		Miscarriages	
Psoriasis		Broken bones		If yes, how many?	
Other skin conditions		Disabling back pain		Contraception	
		Degenerative arthritis		Last menstrual period Date	
Thyroid disease		Osteoporosis		Age at menopause	
Diabetes		Raynaud's		Estrogen use	

FAMILY HISTORY:

	Age	Health	Age at Death	Cause
Father				
Mother				
Spouse				

	How many living?	Any medical conditions	Any who died?	List ages each died and causes
Brothers				
Sisters				
Children				

Does anyone in your family have;

Rheumatoid arthritis ☐ Yes ☐ No Ankylosing spondylitis ☐ Yes ☐ No Colitis ☐ Yes ☐ No

Lupus ☐ Yes ☐ No Psoriasis ☐ Yes ☐ No

Muscle Disease ☐ Yes ☐ No Thyroid Disease ☐ Yes ☐ No

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Your occupation:_____

Are you currently working? Yes No

If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No

If yes, for what disability?

_____

What date did this disability begin?

_____

Your marital status:single marriedseparated

divorced widowed

Do you smoke cigarettes? Yes No In Past

If yes, how many packs a day? _____

How many years have you smoked?_____

Do you smoke cigars or a pipe? Yes No

If yes, how many per day? _____

Do you drink alcohol? Yes No

If yes, number of drinks/glasses per week? _____

Do you drink caffeinated beverages? Yes No

Cups/glasses per day? _____

Do you exercise regularly? Yes No

Type & frequency: _____

_____

Have you ever used illegal or recreational drugs?

Yes No

If yes, please list type_____

How many hours do you sleep at night?_____

Do you wake feeling rested? Yes No

Have you traveled anywhere In the past 12 months?

Yes No If yes, where? _____