

**West County Rheumatology**

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**New Patient Packet**

# Patient Information

Last Name

:

First Name

:

Address

:

City, State, Zip:

Age:

Sex:

[

]

F [] M

Email:

Date of Birth:

Phone:

Phone:

Marital Status: []

Married [] Single [] Divorced

Employer:

Phone:

Race:

American Indian or Alaska Native []

Asian []

Native Hawaiian or Another Pacific Islander []

Black or African

American [

]

White []

Hispanic [

]

I hereby authorize West County Rheumatology to administer treatment of the above-mentioned patient. I authorize West County Rheumatology to release any medical information acquired in the course of examination or treatment of the above-named patient to his/her insurance company for payment. I authorize payment to be made directly to West County Rheumatology for any services rendered and understand that I am financially responsible to West County Rheumatology for charges not paid by insurance company.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

Patient Signature: Date:

**Family History**

List any conditions that your family has had (**mother, father, brother, sister and grandparents**)

Write which family member on the line

* High Blood Pressure
* Cancer
* Rheumatoid Arthritis
* Joint Pain
* Autoimmune Disease
* Ulcerative Colitis
* Chrohns Disease
* Psoriasis Inflammation
* Eye Disease
* Cardiovascular Disease
* Pulmonary Disease

## List all drug allergies (including food, drug and environmental)

**Allergen:**

**Type of Reaction:**

**List all medications** (you are currently taking. Include such items as aspirin, vitamins, laxatives, and any natural supplements) If you have a copy of your medication list we can make a copy

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|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dose** | **How Many Times per Day?** | **How long have you been taking this medication?** |
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|  |  |  |  |

**List all Surgeries** (**Hysterectomy, knee replacement, shoulder replacement, C- Section etc.)**

|  |  |  |
| --- | --- | --- |
| **Type of Surgery** | **Reason for Surgery** | **Year** |
|  |  |  |
|  |  |  |
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|  |  |  |

# Social History

Have you ever used tobacco products? [] Yes [] No

Having you used chewing tobacco, cigarettes, cigars? [] Yes [] No

Do you currently Smoke? [] Yes [] No

What do you smoke?

Do you use a Vapor Pen? [] Yes [] No

Do you ever drink Alcohol? [] Yes [] No How Often? [] Everyday Monthly [] Weekly [] Rarely []

What Type of Alcohol?

### Do you use recreational drugs? (cocaine, heroin, methamphetamine, marijuana)

[] Yes [] No

# Systems Review

As your review the following list, please check any of those problems, which have significantly affected you.

## CONSTITUTIONAL

* Recent weight gain Amount
* Recent weight loss Amount
* Weakness
* Fever
* Fatigue

## EYES

* Loss of vision
* Double or blurred vision
* Eye Pain
* Dry Eye

## EAR-NOSE-MOUTH-THROAT

* Bleeding gums
* Loss of hearing
* Nosebleeds
* Runny nose
* Sores in mouth
* Loss of taste
* Dryness of mouth
* Difficulty in swallowing
* Ringing in ears

## CARDIOVASCULAR

* Pain in chest
* Heart murmurs
* Irregular heartbeat
* Sudden changes in heartbeat
* High blood pressure

## MUSCULOSKELETAL

* Joint stiffness
* Joint pain
* Joint swelling
* Muscle weakness
* Muscle Pain
* Ankylosing Spondylitis
* Rheumatoid Arthritis
* Bone Infection (Osteomyelitis)
* Bursitis
* Bunion
* Connective Tissue Disease
* Dermatomyositis
* Fasciitis
* Kyphosis
* Lumbago
* Myositis Infection
* Osteopenia
* Osteoporosis
* Polyarthropathy
* Polymyositis
* Rotator Cuff Syndrome
* Scoliosis
* Spondylosis
* Club Foot

## GASTROINTESTINAL

* Nausea
* Vomiting
* Stomach pain
* Blood in stools
* Jaundice
* Diarrhea
* Black stools
* Heartburn
* Constipation
* Chrohns Disease/Ulcerative Colitis
* Irritable Bowl Syndrome

## GENITOURINARY

* Difficult urination
* Pain or burning on urination
* Rash/ulcers
* Blood in urine
* Chronic Urinary Tract Infection

## RESPIRATORY

* Shortness of breath
* Wheezing
* Swollen legs or feet
* Cough
* Coughing up blood
* Pulmonary Nodules

## INTEGUMENTARY (SKIN AND/OR BREAST)

* Easy bruising
* Redness
* Rash
* Hives
* Hair loss
* Skin Tightness
* Nodules/bumps
* Color changes of hand or feet in the cold

## NEUROLOGICAL

* Headaches
* Dizziness
* Night sweats
* Sensitivity or pain of hands and/or feet
* Memory loss
* Fainting
* Muscle spasm
* Loss of consciousness

## HEMATOLOGIC/LYMPHATIC

* Blood transfusion
* Swollen glands
* Anemia
* Bleeding tendency
* MTHFR

**ENDOCRINE**

* Excessive thirst

## ALLERGIC/IMMUNOLOGIC

* Frequent sneezing
* Increased susceptibility to infection