Joint Endeavors
Specialists in Rheumatology

Pre-Infusion Health Questionnaire

Name_____

Date of birth_____ Today's Date _____

Please **circle yes** or **no** if you have had any of the following in the past two weeks:

Fever	Y	N	Night sweats	Y	N
Headache	Y	N	Sore Throat	Y	N
Sinus infection	Y	N	Ear ache	Y	N
Toothache	Y	N	Cough	Y	N
Shortness of breath	Y	N	Cold symptoms	Y	N
Chest pain	Y	N	Painful urination	Y	N
Blood in urine	Y	N	Open wound	Y	N

Have you had surgery since last visit? Y N Surgical complications? Y N

Diagnosed with any infections? Y N _____

When was your last visit with your primary provider? _____

Please **circle** if any of the following has been diagnosed since your last doctor visit:

Tuberculosis Hepatitis Congestive Heart Failure COPD/emphysema

Cancer Multiple Sclerosis

Any new vaccinations? Y N _____

Any new allergies? Y N Latex? Y N Tape? Y N

Please **explain** items that you circled in the space below or add any new health information:

_____

_____

Patient signature:_____ MD_____