RHEUMATOLOGY PATIENT QUESTIONNAIRE

Completion of this form will help you recall information your doctor needs in evaluating your health and will serve as a guide for your doctor in obtaining your medical history.

Name ______________________________ Date __________ Date of Birth ______________

I wish to see the doctor for: ______________________________

What are the things bothering you? ______________________________

____

FAMILY HEALTH HISTORY:

	Age	State of Health	Age at Death	Cause of Death or Poor Health
Mother				
Father				
Brother(s)				
Sister(s)				
Children				

Check diseases known to have occurred in the family:

- ❏ Rheumatoid Arthritis
- ❏ Lupus
- ❏ Osteoarthritis
- ❏ Gout
- ❏ Tuberculosis

ABOUT YOURSELF

Present Occupation ______________________________ ❏ Single ❏ Married ❏ Widowed ❏ Divorced

Previous Occupation ______________________________ Live with: ❏ Your Family ❏ Alone

Tobacco Use? ❏ Yes ❏ No Type __________ How Long? __________ Do you drink any alcohol? ❏ Yes ❏ No

Allergies to:

Medicines ______________________________ Others ______________________________

Do you take medications regularly? ❏ Yes ❏ No If yes,

List Medications: Please include over the counter medications.

1. ____________ Dose ____________ Times per day ____________ How long ____________
2. ____________ Dose ____________ Times per day ____________ How long ____________
3. ____________ Dose ____________ Times per day ____________ How long ____________
4. ____________ Dose ____________ Times per day ____________ How long ____________
5. ____________ Dose ____________ Times per day ____________ How long ____________
6. ____________ Dose ____________ Times per day ____________ How long ____________

Past History

Serious Illness as a Child: ____

____

Surgeries:	Type or Cause	When and Where

Injuries:	Type or Cause	When and Treatment

Have you been in the hospital other than surgeries? ❑ Yes ❑ No When and Where? ______________________

Check any of the following illnesses with which you have been diagnosed and provide details in the space provided. Please answer each question. Any left blank will be considered negative in your medical record.

Yes	No		When
❑	❑	Fever, Chills, Night Sweats	______________
❑	❑	Severe/Frequent Headache	______________
❑	❑	Periods of Unconsciousness	______________
❑	❑	Complete/Partial Blindness	______________
❑	❑	Dry Eyes	______________
❑	❑	Hearing Trouble	______________
❑	❑	Dry Mouth	______________
❑	❑	Mouth Sores	______________
❑	❑	Hay fever or Sinus Trouble	______________
❑	❑	Nose Sores	______________
❑	❑	Goiter or Thyroid Trouble	______________
❑	❑	Asthma	______________
❑	❑	Cough	______________
❑	❑	Shortness of Breath	______________
❑	❑	Coughed up Blood	______________
❑	❑	High Blood Pressure	______________
❑	❑	Have you been told you have heart trouble	______________
❑	❑	Have you ever had jaundice or hepatitis	______________

Yes	No		When
❑	❑	Fast, Irregular, or slow pulse	______________
❑	❑	Pain In Chest	______________
❑	❑	Vomit Blood	______________
❑	❑	Recent change in bowel habits	______________
❑	❑	Black or bloody bowel movements	______________
❑	❑	Diarrhea	______________
❑	❑	Frequent indigestion or gas	______________
❑	❑	Ulcer of stomach or intestine	______________
❑	❑	Burning with urination	______________
❑	❑	Blood in urine	______________
❑	❑	Frequency of urination	______________
❑	❑	Kidney Stones	______________
❑	❑	Protein or Albumin in urine	______________
❑	❑	Sexually transmitted diseases	______________
❑	❑	Diabetes	______________
❑	❑	Numbness in hands or feet	______________
❑	❑	Do you feel anxious, depressed, or irritable?	______________
❑	❑	Skin Rash	______________
❑	❑	Do you sleep well	______________
❑	❑	Do you feel rested upon waking	______________

Has your weight changed in the past year? ❑ Yes ❑ No How much? ____________ Recent Weight? ________

Weight 1 year ago? (approximately)________

Weight 5 years ago (approximately) _________

For Women

Number of Pregnancies?______Miscarriages______Living Children______

Age when menstrual period began_____ End_____

MANA NORTH HILLS CAMPUS

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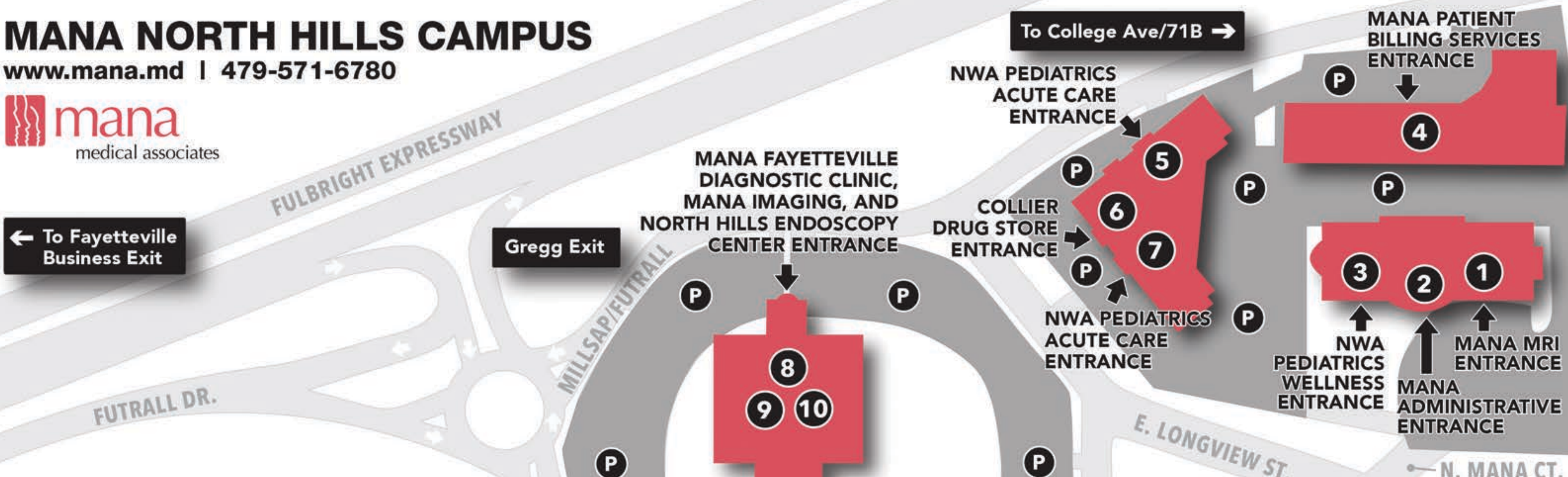

BUILDING LEGEND

1. **MANA MRI**
   3383 N Mana Ct #102 | Fayetteville, AR 72703
2. **MANA Administrative Office**
   3383 N Mana Ct #201 | Fayetteville, AR 72703
3. **Northwest Arkansas Pediatrics Wellness Clinic (Blue)**
   3383 N Mana Ct #101 | Fayetteville, AR 72703
4. **MANA Patient Billing Services**
   237 E. Millsap, Suite #5 | Fayetteville, AR 72703
5. **Northwest Arkansas Pediatrics Acute Care II**
   3380 N Futrall Dr. | Fayetteville, AR 72703
6. **Collier Drug Store**
   3380 N Futrall Dr. #2 | Fayetteville, AR 72703
7. **Northwest Arkansas Pediatrics Acute Care 1 & Walk-in Clinic (Red)**
   3380 N Futrall Dr. | Fayetteville, AR 72703
8. **North Hills Endoscopy Center**
   3344 N Futrall Dr #3 | Fayetteville, AR 72703
9. **MANA Imaging (CT, Ultrasound, Bone Density, X-ray)**
   3344 N Futrall Dr. | Fayetteville, AR 72703
10. **MANA Fayetteville Diagnostic Clinic**
   3344 N Futrall Dr. | Fayetteville, AR 72703
11. **Renaissance Women's Healthcare**
   3302 N North Hills Blvd | Fayetteville, AR 72703

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