



# Texas Rheumatology

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## New Patient Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Phone: \_\_\_\_\_

### Medical/Past Medical History: Please check all that apply below

|                     |  |                        |  |                  |  |                       |  |
|---------------------|--|------------------------|--|------------------|--|-----------------------|--|
| Osteoarthritis      |  | Rheumatoid Arthritis   |  | Lupus            |  | Gout                  |  |
| Fibromyalgia        |  | Ankylosing Spondylitis |  | Psoriasis        |  | Psoriatic Arthritis   |  |
| Sjogren's           |  | Crohn's                |  | Osteoporosis     |  | Sleep Apnea           |  |
| Glaucoma            |  | Migraine Headaches     |  | Tuberculosis     |  | Anemia                |  |
| HIV/STDs            |  | Celiac Disease         |  | GERD             |  | Stomach Ulcers        |  |
| High Blood Pressure |  | Asthma                 |  | Depression       |  | Anxiety               |  |
| Heart Attack        |  | Heart Disease/CHF      |  | Diabetes, Type:  |  | Cancer, Type:         |  |
| Blood Clots         |  | Diverticulitis         |  | Hepatitis, Type: |  | High Cholesterol      |  |
| Emphysema/COPD      |  | Neuropathy             |  | Stroke           |  | Epilepsy/Seizures     |  |
| Pneumonia           |  | Liver Disease          |  | Thyroid Disease  |  | Kidney Disease/Stones |  |

Any other pertinent past medical history you wish to include:

### Past Surgical History: Please indicate year for all those that apply below

|                            | Year |              | Year |                | Year |                  | Year |
|----------------------------|------|--------------|------|----------------|------|------------------|------|
| Knee Replacement: R L Both |      | Neck Surgery |      | Tubal Ligation |      | Gall Bladder     |      |
| Hip Replacement: R L Both  |      | Back Surgery |      | Hysterectomy   |      | Weight Loss      |      |
| Shoulder Surgery           |      | Feet Surgery |      | Colon Surgery  |      | Vascular Surgery |      |
| Arthroscopic Surgery:      |      | Hand Surgery |      | Carpal Tunnel  |      | Cardiac Surgery  |      |

Other past surgical history:

### Present Medications: List all medications and doses, including over the counter medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medication Allergies: List any medication allergies and associated reactions you have

\_\_\_\_\_  
\_\_\_\_\_

**Social History:** Do you drink alcohol? \_\_\_\_\_ If yes, estimate the number of drinks per week: \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ Current? \_\_\_\_\_ How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_ Have you ever used illegal drugs? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_ Do you exercise regularly? \_\_\_\_\_ How often and how long? \_\_\_\_\_ Occupation: \_\_\_\_\_

### Family History: Please state blood relatives that have any of the following

|                 |                                |
|-----------------|--------------------------------|
| Osteoarthritis: | Rheumatoid Arthritis:          |
| Gout:           | Fibromyalgia:                  |
| Lupus:          | Ankylosing Spondylitis:        |
| Osteoporosis:   | Crohn's/ Ulcerative Colitis:   |
| Sjogren's:      | Psoriasis/Psoriatic Arthritis: |