PEDIATRIC

Tulsa Bone & Joint Rheumatology Questionnaire
Please fill out ALL information to the best of your knowledge

NAME:________________________ AGE:_______ DATE OF BIRTH:_____________
WHO REFFERED YOU TO US? ____
PRIMARY CARE PHYSICIAN:____
BRIEF SUMMARY OF THE REASON FOR YOUR VISIT: ________________________
____

PAST MEDICAL AND SURGICAL HISTORY: Place an **X** by those that apply:

- ☐ Asthma
- ☐ Anemia
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Frequent Colds
- ☐ Low Thyroid
- ☐ Cancer (please specify type)
- ☐ Depression
- ☐ Appendectomy
- ☐ Constipation
- ☐ Gallbladder
- ☐ Rheumatic Fever
- ☐ Vision Problems

OTHER MEDICAL OR SURGICAL HISTORY:_____________________
____
____
____
____
____
____
____
____
____
____
____

SYSTEMS REVIEW: Please circle any of the following symptoms you've had in the last few months:

GENERAL: • Weight loss (not from dieting) •Fatigue •Fever
GI: •Abdominal Pain •Reflux •Food sticking in esophagus
SKIN: •Facial Rash •Rash caused by sunlight
PULMONARY: •Pain with breathing •Shortness of Breath •Coughing up Blood
CARDIOVASCULAR: •Chest Pain •Raynauds (blue/white hand color in cold)
NEUROLOGIC: •Severe Headaches •Seizures •Peripheral Neuropathy
ENT: •Sores in nose/mouth •Bloody sinus drainage
EYES: •Excessive Dryness •Painful red Eye
ID: •Recent Infections •History of Positive TB skin test
PSYCH: •Depression •Anxiety
GENITOURINARY: •Blood in Urine •History of miscarriages

Birth Weight:__________________ Birth Length:_________________________
Were there any concerns about growth or progress made in areas such as rolling over, sitting, walking, ability to ride a tricycle, dress self and feed self?__________________
If yes, please describe:____
____
Are there concerns about language or speech development?________________
If yes, please describe:____
____

Rheumatology Health Questionnaire (Continued)

DRUG ALLERGIES (include type of reaction):

____

____

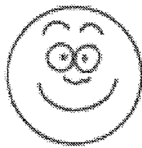
____

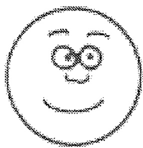
CURRENT MEDICATIONS (Include the dose if possible):

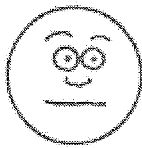
Example: Motrin 600mg 3 times daily

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOUR ARTHRITIS MAKES YOU FEEL


0
No Hurt


1
Hurts
Little Bit


2
Hurts
Little More

3
Hurts
Even More

4
Hurts
Whole Lot

5
Hurts
Worst

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PRIMARY CARE PHYSICIAN:______________________________
BRIEF SUMMARY OF THE REASON FOR YOUR VISIT: ______________
____

PAST MEDICAL AND SURGICAL HISTORY: Place an **X** by those that apply:

- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Reflux Esophogitis
- ☐ Low Thyroid
- ☐ Cancer (please specify type)
- ☐ Depression
- ☐ Appendectomy
- ☐ Coronary Bypass
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Pacemaker

OTHER MEDICAL OR SURGICAL HISTORY :____________________
____

SYSTEMS REVIEW: Please circle any of the following symptoms you've had in the last few months:

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GENITOURINARY: •Blood in Urine •History of miscarriages

Name of Your Employer:______________________________
Describe Your Specific Job:______________________________
Do You Smoke? Circle One: NO QUIT YES (packs per day?) __________
Do you drink alcohol? NO QUIT YES (drinks per week?):__________
MARITAL STATUS: Circle one: Married Widowed Divorced Single
FAMILY HISTORY: Circle any: Arthritis Lupus Osteoporosis
Other:____
____

Rheumatology Health Questionnaire (Continued)

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____

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____

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8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____

Pain Numeric Rating Scale

1. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst pain imaginable, how would you rate you pain RIGHT NOW?

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worst Pain**

2. On the same scale, how would you rate your WORST pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Worst Pain**