St. Paul Rheumatology, P.A.
HELPING YOU LIVE A BETTER LIFE

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Dear: _____

Your appointment with **Dr. Ridley / Dr. Moreta** is scheduled on _____ at ____ AM/ PM at our Eagan / Roseville office.

When you arrive at your appointment, please ensure you have done the following things.

- Call your primary or referring doctor to request the following medical records:
  a) Last two office visit notes (within the past 12 months)
  b) Last physical (if you have one)
  c) Most recent blood works.
- Please have them faxed to 651-644-4018. If we have not received the required paperwork prior to appointment, you may be asked to re-schedule.
- Contact your insurance company to see if a referral is required to be seen by our physicians.
- Bring your medical and prescription (Rx) insurance cards.
- Complete all of the paperwork that you have received.
- Bring a current list of any and all medications that you are currently taking. If you are unsure, please feel free to bring them in and the nurses will assist you in compiling your list.

If you have any questions please feel free to contact us at 651-644-4277.
Thank you and we look forward to meeting you.

AARA Saint Paul Rheumatology Clinic – New patient questionnaire

Date of first appointment: _____/_____/_____ (Day / Month / Year)

Birthplace: _____

Name: _____

Date of birth: _____/_____/_____ (Day / Month / Year)

Address: _____

Age: _____ Sex: ☐ Female ☐ Male

_____ (City / State / Zip)

Telephone: Home ( )_____

Work ( ) _____

Occupation: _____

Marital Status: _____

Referred by: □ Self □ Family □ Family Doctor □ Other health professional

Name of the person making Referral: _____ Physician Phone number: _____

If you have an Orthopedic surgeon, please provide name: _____ Phone: _____

1. Describe briefly your present symptoms:

   Date symptoms began (approximately): _____ Diagnosis given: _____

2. Are your symptoms (circle true statements) Give details:

   a) Worse in the morning.
   b) Worse in the evening
   c) Helped by exercise or use
   d) Worsened by exercise or use
   e) Affected by weather
   f) Affected by other factors

3. Have you noticed redness, swelling, or warmth of any parts of your body? ☐ No ☐ Yes ☐ Uncertain
   If you answered yes, please give details:

4. Are you awakened from sleep by your symptoms? ☐ No ☐ Yes (check one)

5. When you get up in the morning, are you stiff? ☐ No ☐ Yes ☐ Uncertain (check one)
   If you answered yes, how many minutes (or hours) does it take you to limber up each morning?

   Hours: _____ Minutes: _____

This questionnaire asks for information that no blood tests, X-rays, or any source other than you can give. Please answer each question, even if you feel it is not related to you at this time. There are NO right or wrong answers so please answer exactly as you think or feel.

Who referred you to this clinic?	□ Self □ Primary Care Physician □ OB/GYN □ Rheumatologist □ ER/Urgent care □ Friend □ Other

1. When you get up in the morning, do you feel stiff? □ Yes □ No	2. If your answer to question 1 was "yes", how long does it take until you are as limber as you will be for the day? __ __ Hours __ __ Min.

3. Please fill either a 'NO' or 'YES circle for each of the following conditions to indicate if you have EVER had it. Whenever you answer 'YES', please fill in the ONE best answer about when it began.	**NO**	**Yes Less than 1 year ago**	**Yes 1-5 years ago,**	**Yes More than 5 years ago,**
a) High blood pressure(hypertension)	□	□	□	□
b) Heart attack	□	□	□	□
c) Angina	□	□	□	□
d) Other heart disease	□	□	□	□
e) Congestive heart failure	□	□	□	□
f) Stroke/Mini stroke	□	□	□	□
g) Cancer (type_____)	□	□	□	□
h) Skin Cancer (not melanoma)	□	□	□	□
i) Skin cancer (melanoma)	□	□	□	□
j) Lymphoma	□	□	□	□
k) Lung cancer	□	□	□	□
l) Breast cancer	□	□	□	□
m) Bronchitis or emphysema	□	□	□	□
n) Anemia	□	□	□	□
o) Other blood problem	□	□	□	□
p) Stomach or duodenal (peptic) ulcer	□	□	□	□
q) Gastroesophageal reflux (GERD)	□	□	□	□
r) Gastrointestinal bleed (GI Bleed)	□	□	□	□
s) Thyroid problem	□	□	□	□
t) Diabetes (sugar)	□	□	□	□
u) Psoriasis	□	□	□	□
v) Back or spine problems	□	□	□	□
w) Osteoporosis	□	□	□	□
x) Broken bones after age 50	□	□	□	□
y) Cataracts	□	□	□	□
z) Depression	□	□	□	□
aa) Alcoholism	□	□	□	□
bb) Liver disease	□	□	□	□

4. Have you had any of the following surgeries? Please list all boxes that apply.

A. Replacement (arthroplasty) of:		B: Other surgeries:	
□ Left Knee	□ Lett Hip	□ Open heart	□ Chest (not open heart)
□ Left Knuckles	□ Left Shoulder	□ Abdomen	□ Hysterectomy
□ Right Knee	□ Right Hip	□ Prostate	□ Breast
□ Right Knuckles	□ Right Shoulder	□ Angioplasty or Stent	

C. Check here □ if you haven't had ANY of the surgeries listed above.

5. Have you ever been hospitalized for any of the following? Please fill al boxes that apply.
□ Surgery □ Heart □ Ulcer □ Pneumonia □ Other infection □ Other reason □ No hospitalizations

NOTE: If your family history is complete unknown to you, please fill this box □ and go to question 8 on the next page.

6. On each row below, please read the disease and then fill the boxes under any family members who have had it **FAMILY HISTORY:**	**Father**	**Mother**	**Brother(s)**	**Sister(s)**
a) Heart Disease/Heart attack (MI)	□	□	□	□
b) Cancer of the colon or rectum	□	□	□	□
c) Any other cancer	□	□	□	□
d) Diabetes Mellitus	□	□	□	□
e) Stroke	□	□	□	□
f) Alzheimer's Disease	□	□	□	□
g) Fracture of hip, spine or wrist AFTER age 50	□	□	□	□

7. On each row below, please read the disease and then fill the boxes under any family members who have had it. **FAMILY HISTORY:**	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Child**	**Aunt**	**Uncle**
a) Rheumatoid arthritis	□	□	□	□	□	□	□
b) Osteoarthritis or degenerative arthritis	□	□	□	□	□	□	□
c) Lupus (SLE)	□	□	□	□	□	□	□
d) Osteoporosis	□	□	□	□	□	□	□
e) Psoriatic arthritis	□	□	□	□	□	□	□
f) Psoriasis	□	□	□	□	□	□	□
	□	□	□	□	□	□	□

8. Fill in each box for any medical condition you have had.

□ Unusual fatigue □ Loss of appetite □ Skin rash or hives □ Psoriasis □ Loss of hair □ Muscle pain, aches or cramps □ Muscle weakness □ Pregnancy □ Shortness of breath □ Pain in the chest	□ Heart pounding (palpitations) □ Swelling of ankles (edema) □ Dark or bloody stools □ Dry eyes □ Sores in the mouth □ Dry mouth □ Cough □ Wheezing □ Dizziness □ Back pain	□ Numbness or tingling of arms or legs □ Depression (feeling blue) □ Anxiety (feeling nervous) □ Problems with thinking/confusion □ Problems with memory/forgetfulness □ Problems with sleeping □ Trouble swallowing □ Heartburn or stomach gas □ Stomach pain or cramps

Fill this box □ if you haven't had *ANY* of these medical conditions.

9. Indicate the drug(s) with which you are *CURRENTLY* being treated. Do not include drugs you are starting after this office visit.

i. RHEUMATOLOGIC IMMUNOSUPRESANT MEDICTIONS/DMARD's

□ I am NOT taking any DMARD's

Oral medications	□ Arava (leflunomide) □ Azulfidine (sulfasalazine) □ Imuran (azathioprine)	□ Methotrexate (tablets or liquid) □ Minocin (minocycline) □ Neoral (cyclosporine)	□ Plaquenil (hydroxychloroquine) □ Other: _____ □ Not sure
Injectable medications	□ Enbrel □ Humira □ Kineret □ Methotrexate (injection) □ Cosentyx	□ Cimzia □ Actemra (injection) □ Kevzara □ Orencia □ Otezla	□ Stelara □ Simponi □ Talz □ Xeljanz
Infusion medications	□ Actemra □ Orencia □ Remicade □ Rituxan □ Simponi Aria □ Renflexis □ Inflectra □ Benlysta	Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____ Date of last infusion: _____	

If you use injectable medications or receive infusions (drugs given through the vein):

Did you experience redness, stinging, or a rash at the site of the injections? □ No □ Yes
Did you experience a painful or burning sensation with drug administration? □ No □ Yes

For patient's receiving intravenous infusions: Did you experience an infusion reaction on this drug?
(Chest tightness, change in blood pressure, rash, palpitations, breathing problems). □ No □ Yes

ii. NSAID's

□ I'm not taking any NSAID's
□ Aspirin (81mg [baby] or 325mg)
□ Celebrex
□ Ibuprofen
□ Naproxen
□ Other NSAID _____
□ I'm not sure

iii. Osteoporosis drugs

□ I'm NOT taking any osteoporosis drugs
□ Actonel
□ Aredia (pamidronate)
□ Didronel (etidronate)
□ Estrogren
□ Evista (raloxifene)
□ Prolia
□ Fosomax (alendronate)
□ Miacalcin (Calcitonin)
□ Boniva (ibandronate)
□ Reclast (zoledronic acid)
□ Other osteoporosis drug(s)
□ I'm not sure

9. Cont'd… OVER THE PAST 8 WEEKS have you taken any of the following drugs? Please fill all boxes that apply.

GI Meds	Antidepressants	Analgesics
□ I'm not taking any of the following GI meds	□ I'm not taking any of the following antidepressants	□ I'm not taking any of the following analgesics
□ Prilosec (omeprazole)	□ Prozac (fluoxetine)	□ Tylenol (acetaminophen)
□ Prilosec OTC (omeprazole)	□ Zoloft (seraline)	□ Advil, Nuprin (ibuprofen)
□ Prevacid (lansoprazole)	□ Paxil (paroxetine)	□ Alleve (naproxen)
□ Aciphex (rabeprazole)	□ Celexa (citalopram)	□ Ultram (tramadol)
□ Protonix (pantoprazole)	□ Effexor (venlafaxine)	□ Darvon (propoxyphene)
□ Nexium (esomeprazole)	□ Wellbutrin (bupropion)	□ Tylenol with codeine
□ Cytotec (misoprostol)	□ Elavil (amitriptyline)	□ Lortab, Vicodin (hydrocodone)
	□ Lexapro (excitalopram oxalate)	□ Percocet (oxycodone)
	□ Cymbalta (duloxetine HCI)	□ Pain patch

OVER THE PAST 8 WEEKS have you taken a **Medro-pac?** □ No □ Yes

OVER THE PAST 8 WEEKS have you taken any **Prednisone?** (if yes please indicate the most recent dose)
□ No □Yes → □ 1mg □ 2 - 2.5mg □ 3 - 4mg □ 5 - 7mg □ 7.5 - 9mg □ 10mg or more (daily)

10. What drugs have you taken in the past, but DO NOT TAKE NOW?

□ Enbrel	□ Stelara	□ Inflectra	□ Evista (raloxifene)
□ Humira	□ Simponi	□ Benlysta	□ Prolia
□ Kineret	□ Taltz	□ Actonel	□ Plaquenil
□ Methotrexate (injection)	□ Xeljanz	□ Fosamax (alendronate)	□ Cuprimine
□ Cosentyx	□ Actemra	□ Aredia (pamidronate)	□ Evista
□ Cimzia	□ Orencia	□ Miacalcin (Calcitonin)	□ Neoral
□ Actemra (injection)	□ Remicade	□ Didronel (etidronate)	□ Ridaura
□ Kevzara	□ Rituxan	□ Boniva (ibandronate)	□ Solganal
□ Orencia	□ Simponi Aria	□ Estrogren	
□ Otezla	□ Renflexis	□ Reclast (zoledronic acid)	

11. Which of the following have you taken OVER THE PAST 8 WEEKS?
□ Check here if you haven't taken ANY of these OVER THE PAST 8 WEEKS.
□ Glucosamine → □ 1500mg □ 1000mg daily or less
□ Cholesterol lowering agent (Lipitor, Lescol, Mevacor, Pravachol, Altocor, Crestor, Zocor, Vytorin)
□ Chondroitin □ Folic Acid □ Fish Oil □ Other non-prescription remedy or remedies
□ Plavix □ Evening Primrose oil □ Coumadin □ Borage Seed oil □ Librel □ Flax seed oil

12. Do you exercise? □ Not at all □ 1-2 times per week □ 3-4 times per week □ 5-6 times per week □ Daily
13. Do you smoke cigarettes? □ No, never □ Yes, Currently □ Yes, previously □ Yes, only socially
14. Do you drink alcoholic beverages? □ Not at all □ 1-3 per week □ 1-2 daily □ 3or more daily □ Occasionally
15. Do you take you medication as prescribed?
□ 0-25% □ 25-50% □ 50-75% □ 75-95% □ 95-100% if the time

16. Gender □ Male □ Female 17. Weight ☐☐☐ (lbs.) 18. Height ☐ (ft) ☐☐(in)
19. Are you under 90 years old? □ No □ Yes → If "yes" Your year of birth _ _ _ _ (e.g. 1945)
20. Current work status: □ Full-time □ Part-time □ Student □ Disabled □ Retired □ Not employed
21. Number of days lost from work over the past 3 months because of illness: _____.
22. Your living arrangements: □ Spouse/Partner □ Sibling □ Parents □ Children □ Alone □Sr. Residence
23. Your final year of education: □ Primary □ High School □ College/University □ Don't remember
24. Marital Status □ Single □ Married □ Partnered □ Widowed □ Separated □ Divorced
25. Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino
26. Race: (fill all that apply) □ White □ Black/African American □ Asian □ American Indian or Alaskan Native
□ Native Hawaiian or Pacific islander □ Other Pacific Islander
27. Your insurance type: □ Private □ Medicare □ Medicaid □ No insurance