St Thomas Rheumatology Consultants

Name: _____ Date of Birth: _____

Describe briefly your present Symptoms:

Date symptoms began (approximately):

Diagnosis:

Previous Treatment for this Problem INCLUDING medications:

PRESENT MEDICATIONS (List any medications you are taking, including such items as aspirin, vitamins, laxatives, calcium and other supplements, etc)

Name of Drug	Dose and frequency	Name of Drug	Dose and Frequency
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

Allergies

List	Reaction	List	Reaction
1.		4.	
2.		5.	
3.		6.	

Previous Operations/ Hospital Stays

TYPE	Year	TYPE	Year
1.		6.	
2.		7.	
3.		8.	
4.		9.	

SYSTEMS REVIEW RHEUMATOLOGY

As you review the following list, please check any of those problems which have significantly affected you.

	Persistent Fevers		Dry eyes		Blood in urine
	Fatigue		Dry mouth		Protein in urine
	Loss of appetite		Vaginal dryness		Blood clots
	Weight loss		Dry Skin		Numbness/tingling
	Hair loss – patchy or diffuse		Psoriasis		Fluid around your heart
	Sun sensitivity		Skin Rash		Fluid around your lungs
	Color Changes in hands in cold		Skin Tightening		Anemia, low white count, low platelets
	Sores in mouth		Miscarriages		Ulcerative Colitis/ Crohn's Disease
	Muscle weakness				Memory Change

Joint Pain: Yes or No	Joint Swelling: Yes or No
Duration (how long?) _____	
Locations (List all places that hurt) 1,_____ 2. _____ 3. _____ 4._____ 5._____	Locations (List all places that swell) 1,_____ 2. _____ 3. _____ 4._____ 5._____
Does pain change with activity? - Better or worse?	Morning Stiffness? Yes or No..... -.If yes, how long? _____

Please circle any of these medications that you have tried before:

Hydroxychloroquine (Plaquenil)	Enbrel	Rinvoq
Methotrexate	Humira or biosimilars	Olumiant
Leflunomide (Arava)	Remicade or biosimilars	Xeljanz
Sulfasalazine	Cimzia	Cosentyx
Cellcept (Mycophenolate)	Simponi or Simponi Aria	Taltz
Imuran (Azathioprine)	Orencia	Bimzelx
Rituxan or biosimilars	Actemra or biosimilars	Stelara
IVIG	Kevzara	Tremfya
Avacopan	Benlysta	Skyrizi
Arcalyst	Saphnelo	Otezla
	Lupkynis	

I have read and understand the office policies for STRC regarding payment, late cancellations, medication refills and communication of test results _____Patient Initial Here