The Polyclinic Rheumatology Consultation Form

Ph: 206.860.5580   Fax: 206.860.5484

THE POLYCLINIC

Name: ______________________________________

Marital Status: Single, Married, Partnered, Other   Number of Children: ________

Education, mark highest level attended (optional): Grade____ College ____ Graduate____

Occupation/Employment: ______________________

Details of personal life you'd like to share:_________________________

Referred by: ☐ self ☐ family ☐ friend ☐ doctor ☐ other health care professional

Name of person making referral: ____

Name of your primary care provider: ____

Reason for consultation (problem/symptoms) ____

____

____

____

Approximate date symptoms began: _________________________________

Names of other providers you have seen for this condition and dates if known: ________________________

____

Prior treatments for the above condition: _______________________________

____

Have you ever taken: (check if yes)

- ☐ Steroids (prednisone, Medrol, etc.)
- ☐ Bisphosphonates (alendronate, etc.)
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Minocycline (Minocin)
- ☐ Sulfasalazine (Azulfidine/Sulfazine)
- ☐ Methotrexate (Rheumatrex, Otrexup)
- ☐ Leflunomide (Arava)
- ☐ Azathioprine (Imuran)
- ☐ Mycophenolate mofetil (Myfortic, Cellcept)
- ☐ Cyclosporine (Sandimmune, Prograf)
- ☐ Cyclophosphamide (Cytoxan)
- ☐ Ofacitinib (Xeljanz)
- ☐ Ustekinumab (Stelara)
- ☐ Apremilast (Otezla)
- ☐ Nsaids (ibuprofen, naprosyn, etc.)
- ☐ Blood thinners (Coumadin, etc.)
- ☐ Adalimumab (Humira)
- ☐ Certolizumab (Cimzia)
- ☐ Etanercept (Enbrel)
- ☐ Golimumab (Simponi)
- ☐ Infliximab (Remicade)
- ☐ Rituximab (Rituxan)
- ☐ Abatacept (Orencia)
- ☐ Anakinra (Kineret)
- ☐ Tocilizumab (Actemra)
- ☐ Belimumab (Benlysta)
- ☐ Secukinumab (Cosentyx)

Past Medical History - Do you have or have you had: (check if yes)

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Heart problems
- ☐ Stomach ulcers
- ☐ Recurrent infections
- ☐ Stroke
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Psoriasis (diagnosed by derm)
- ☐ Lung problems
- ☐ Thyroid disease (specify: ____________)
- ☐ Depression
- ☐ Anxiety
- ☐ Tuberculosis or pos TB screen
- ☐ Blood clots needing anticoag
- ☐ Other significant illness: ____

____

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Past Surgical History (surgery type and year, if known):

____

____

Do you smoke? ☐ Never ☐ Yes/in the past (specify packs per day ____ and years _____)

If in the past specify year quit _____________

Do you drink alcohol? ☐ Never ☐ Yes How many glasses/week? _____________

Substance use history including cannabis? ☐ No ☐ Yes_________________________________

Have you used non-prescribed drugs? ☐ No ☐ Yes If yes, please list: _______________

Do you exercise regularly? ☐ Yes ☐ No

If yes, type: ______________________________ hours/week: ___________________

Sexually active: ☐ Yes ☐ No Sexual orientation:____________

Have you traveled outside the US in the last 2 years? ☐ No ☐ Yes______________________________

Family history: unknown/adopted ___ or check/specify any applicable below

☐ Cancer	☐ Psoriasis	☐ Osteoarthritis	☐ Ank spond
☐ Stroke	☐ Thyroid disease	☐ Joint replacement	☐ Uveitis/iritis
☐ Colitis	☐ Rheumatoid arthritis	☐ Hip or spine fractures	☐ Sarcoidosis
☐ Heart disease	☐ Lupus/connective tissue	☐ Diabetes (I or II)	☐ Sjögrens

Autoimmune disorder not listed:____

Other you feel relevant ____

Review of symptoms (check those which have significantly affected you):

☐ Weight loss (___# in last 6 months)	☐ Heartburn
☐ Fatigue	☐ Trouble swallowing
☐ Abdominal pain	☐ Miscarriage/stillbirth
☐ Fever (___ degrees if known)	☐ Nausea/vomiting
☐ Morning stiffness (___ mins)	☐ Liver disease/hepatitis
☐ Hair loss	☐ Frequent diarrhea
☐ Skin rash	☐ Constipation
☐ Hives	☐ Blood in stools or black/tarry stools
☐ Photosensitivity	☐ Jaw pain
☐ Eye pain	☐ Back pain
☐ Dry eyes and/or mouth	☐ Muscle pain
☐ Loss of vision	☐ Muscle weakness
☐ Headache	☐ Chest pain
☐ Tingling/numbness of hands and feet	☐ Trouble breathing
☐ Color changes of fingers/toes in cold	☐ Blood clots
☐ Blood in urine	

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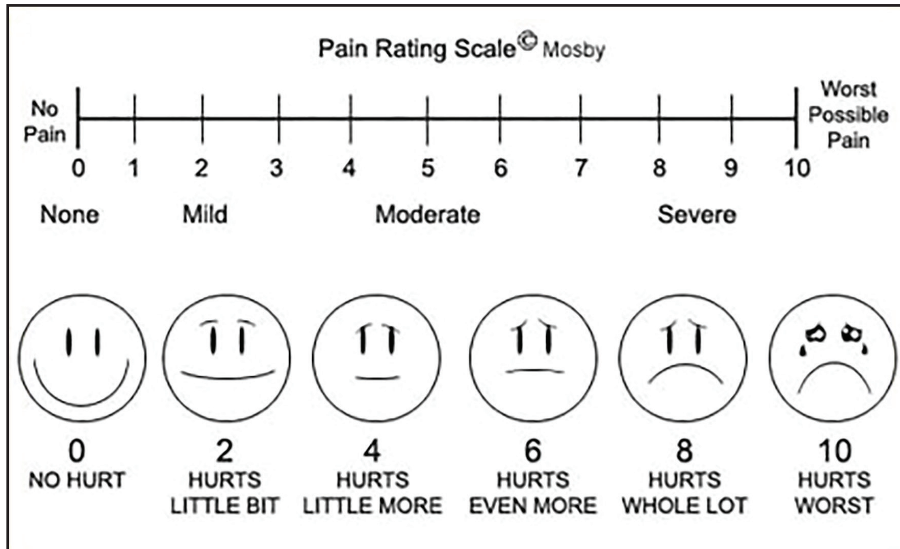
Please circle below how your pain is affecting you today.



Mark these drawings according to where you hurt. Please use the scale below to indicate which sensations you are feeling.

/ / / Stabbing

XXX Burning

+ + + Aching

= = = Numbness

0 0 0 Pins & Needles