Fort Bend Rheumatology Associates

Review of Medications - 2022

Patient Name: DOB: ____ / ____ / ______

Medications

Please list all current medications

____

____

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____

____

Pharmacy

____

Name

____

Address

____

Phone Number

Allergies

If you have any allergies to medications, please list them here and describe your reaction. If none, please write none.

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Fort Bend Rheumatology Associates

Review of Systems Form- 2022

Patient Name:

Constitutional

Neg **Pos**

- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Night sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss
- ☐ ☐ Other:

HEENT

Neg **Pos**

- ☐ ☐ Visual changes
- ☐ ☐ Vision loss
- ☐ ☐ blurred vision
- ☐ ☐ dental cares
- ☐ ☐ Double vision
- ☐ ☐ Dry mouth
- ☐ ☐ Dry eyes
- ☐ ☐ Dysphagia
- ☐ ☐ Epistaxis
- ☐ ☐ Eye Pain
- ☐ ☐ Facial Pain
- ☐ ☐ Hearing loss
- ☐ ☐ Hoarseness
- ☐ ☐ Jaw Pain
- ☐ ☐ Nasal drainage
- ☐ ☐ Nasal sores
- ☐ ☐ Oral ulcers
- ☐ ☐ Red eye
- ☐ ☐ Sinusitis
- ☐ ☐ Sore throat
- ☐ ☐ Tinnitus

Respiratory

- ☐ ☐ Apnea
- ☐ ☐ Cough
- ☐ ☐ Frequent URI
- ☐ ☐ Hemoptysis
- ☐ ☐ Orthopnea
- ☐ ☐ Paroxysmal Nocturnal Dyspnea
- ☐ ☐ Pleuritic pain
- ☐ ☐ shortness of breath
- ☐ ☐ Wheezing

Cardiovascular

Neg **Pos**

- ☐ ☐ Chest pain
- ☐ ☐ Claudication
- ☐ ☐ Edema
- ☐ ☐ Palpitations
- ☐ ☐ Raynaud's
- ☐ ☐ Chest Pain
- ☐ ☐ Tachycardia
- ☐ ☐ Thrombophlebitis
- ☐ ☐ Varicose Veins

Gastrointestinal

Neg **Pos**

- ☐ ☐ Abdominal cramping
- ☐ ☐ Abdominal pain
- ☐ ☐ Bloating
- ☐ ☐ Blood in stools
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Dysphagia
- ☐ ☐ Early satiety
- ☐ ☐ Epigastric pain
- ☐ ☐ Heartburn
- ☐ ☐ Hemorrhoids
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Genitourinary

Neg **Pos**

- ☐ ☐ Dysuria
- ☐ ☐ Genital lesions
- ☐ ☐ Genital ulcers
- ☐ ☐ Hematuria
- ☐ ☐ Impotence
- ☐ ☐ Kidney stones
- ☐ ☐ Nocturia
- ☐ ☐ Pelvic pain
- ☐ ☐ Polyuria
- ☐ ☐ Recurrent UTI
- ☐ ☐ Scrotum/testicular pain
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary incontinence

Metabolic/Endocrine

Neg **Pos**

- ☐ ☐ Cold intolerance
- ☐ ☐ Gynecomastia
- ☐ ☐ Hair loss
- ☐ ☐ Heat intolerance
- ☐ ☐ Hirsutism
- ☐ ☐ Hot flashes
- ☐ ☐ Polydipsia

Neurological

Neg **Pos**

- ☐ ☐ Confusion
- ☐ ☐ Dizziness
- ☐ ☐ Extremity numbness
- ☐ ☐ Extremity weakness
- ☐ ☐ Gait disturbance
- ☐ ☐ Headache
- ☐ ☐ Memory loss
- ☐ ☐ Seizures
- ☐ ☐ Fainting
- ☐ ☐ Tingling
- ☐ ☐ Tremors

Psychiatric

Neg **Pos**

- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Emotionally labile
- ☐ ☐ Hallucinations
- ☐ ☐ Insomnia
- ☐ ☐ Suicidal ideation

Immunologic

Neg **Pos**

- ☐ ☐ Allergic rhinitis
- ☐ ☐ Frequent infections
- ☐ ☐ Food allergies

Integumentary

Neg **Pos**

- ☐ ☐ Acne
- ☐ ☐ Bruising
- ☐ ☐ Discoid rash
- ☐ ☐ Hives
- ☐ ☐ Itching
- ☐ ☐ Nail changes
- ☐ ☐ Photosensitivity
- ☐ ☐ Psoriasis
- ☐ ☐ Rash
- ☐ ☐ Scalp tenderness
- ☐ ☐ Skin lesion

Musculoskeletal

Neg **Pos**

- ☐ ☐ Back pain
- ☐ ☐ Height loss
- ☐ ☐ Joint pain
- ☐ ☐ Joint swelling
- ☐ ☐ Joint tenderness
- ☐ ☐ Low back pain
- ☐ ☐ Morning stiffness
- ☐ ☐ Muscle cramping
- ☐ ☐ Muscle weakness
- ☐ ☐ Muscular atrophy
- ☐ ☐ Myalgia
- ☐ ☐ Neck pain
- ☐ ☐ Neck stiffness

Hematologic

Neg **Pos**

- ☐ ☐ Easy bleeding
- ☐ ☐ Easy bruising
- ☐ ☐ lymphadenopathy

☐ Other:_______________

Fort Bend Rheumatology Associates

Medical History Form - 2022

Patient Name: DOB: ____ / ____ / ______

Past Medical History

Please check all that apply:

- ☐ Arthritis
- ☐ Blood Clots
- ☐ Chronic Back/Joint Problems
- ☐ Depression
- ☐ Emphysema/COPD
- ☐ Heart Disease
- ☐ Head Injury
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Skin Conditions
- ☐ No Past Medical History
- ☐ Asthma
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Glaucoma/Cataracts
- ☐ Headaches/Migraines
- ☐ Hepatitis/Liver Disease
- ☐ High Cholesterol
- ☐ Inflammatory Bowel Disease
- ☐ Seizures
- ☐ Ulcers
- ☐ Stroke

Hospitalization

Have you ever been hospitalized for anything other than surgery or childbirth? If so, please explain why.

Fort Bend Rheumatology Associates

Medical History Form - 2022

Patient Name: DOB: ____ / ____ / ______

Surgeries

Please check if you have had any of the following surgeries:

Cardiac Surgery/Vascular:

☐ Heart Valve Replacement | Heart Bypass Surgery

General Surgery:

☐ Appendix Removed | ☐ Hernia | ☐ Tonsils Removed
☐ Spleen Removed | ☐ Stomach | ☐ Gallbladder Removal
☐ Colon

Skeletal/Orthopedic Surgery:

☐ Back Surgery | ☐ Bone/Join Surgery | ☐ Fracture Repair

Eye:

☐ Glaucoma Surgery | ☐ Cataract Surgery

Female Surgery:

☐ Mastectomy | ☐ Lumpectomy | ☐ Cesarean Section
☐ Tubal Ligation | ☐ Hysterectomy | ☐ Ovaries Removed

Male Surgery:

☐ Vasectomy | ☐ Prostate Surgery

Have you had any other surgeries not listed here? If so, what surgeries?

Fort Bend Rheumatology Associates

Medical History Form - 2022

Patient Name: DOB: ____ / ____ / ______

Family History

Please list all problems/conditions of family members (cancer, heart conditions, diabetes, high blood pressure, blood clots, kidney disease, etc.)

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____

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____

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Social History

	Yes	**No**
Do you drink coffee?	☐	☐
If yes, please state the quantity: ______________________________		
Do you drink alcohol?	☐	☐
If yes, please state the quantity: ______________________________		
Do you use recreation drugs?	☐	☐
If yes, please state the quantity: ______________________________		
Do you exercise regularly?	☐	☐
If yes, please state the quantity: ______________________________		
Do you smoke / use tobacco?	☐	☐
If yes, please state the quantity: ______________________________		