UF PEDIATRIC RHEUMATOLOGY OUT PATIENT VISIT

To be completed by parent/patient (if adolescent):

This form was filled out by:_____
Home#_____
Cell#_____
Work/Other:_____
Address:_____
_____
Pediatrician:_____
Phone:_____
Address:_____
_____
Referring doctor:_____
From filled out by:_____

Patient ID: Name:_____
MRN:_____
DOB:_____
Date:_____

Vitals: **WT (Kg):**_____ **HT(cm):**_____

T:_____ **Pulse:**_____ **RR:**_____

BP:_____ **Age:**_____

Insurance Company: _____**Ph#:**_____
Policy #:_____
Group #:_____
Pharmacy benefits:_____
Pharmacy Name and #:_____

Please complete pages 1 thru 3 at each visit:

Since we last saw you, how would you rate yourself/your child? (circle one)

Same Better Worse N/A Pain level (0-10)_____

Describe:_____

_____

_____

_____

_____

Outpatient services: **How often:** **Last seen:**

Ophthalmology _____ _____ (any problems?_____)

Physical Therapy _____ _____ (_____check if aquatic PT)

Occupational Therapy _____ _____

Assistive Devices (Circle): Wheel chair, walker, splints, orthotics, shoe lift, other_____

Last Set of labs done: when:_____ where:_____

List all current medications including alternative/herbal therapies:

Medication Name	Dose	Frequency

Review of systems: Check yes or no and please comment on the yes answers

	NO	YES	Comments		NO	YES	Comments

Fatigue/Tiredness				Excessive Urination			
Weight loss (how much?)				Excessive Thirst			
Night Sweats				Excessive hunger			
Hair Loss or thinning				Constipation			
EYES:				Dry Skin			
Dry Eyes				**ALLERGY/IMMUNOLOGY:**			
Sensitivity to light				Hives			
Blurry Vision				Chronic Urticaria			
Redness				Rapid swelling of an area			
Eye Pain				Recurrent Infections			
EAR, NOSE, THROAT:				**INFECTIOUS DISEASES:**			List any treatments
Oral Ulcers				Pneumonia			
Nasal Ulcers				Sinusitis			
Dry Mouth				Osteomyelitis			
Congestion				Urinary Tract Infections			
Dental Cavities				Skin Infections			
CARDIOVASCULAR:				Meningitis			
Chest Palpitations				Blood Infections			
Dizziness				**NEUROLOGICAL:**			
Fainting				Headaches			
Decreased endurance				Migraines			
Chest pain				Numbness			
HEMATOLOGY:				Tingling			
Bleeding				Tremors			
Bruising				Weakness			
Nose Bleeds				Seizures			
GASTROINTESTINAL:				**PSYCHOLOGICAL:**			
Nausea (related to meds?)				Depression			
Vomiting				Abnormal Behavior			
Diarrhea				Hallucinations			
Bloody Stools				Difficulties w/school (circle: concentrating, grades, missing)			
Abdominal Pain				Thoughts of Suicide			
Difficulty Swallowing				In Counseling			
RESPIRATORY:				**SKIN:**			
Cough				Rashes			
Chest Pain				Discoloration of Fingers/Toes			
Shortness of Breath				Psoriasis			
Coughing up blood				Eczema			
Aspiration/Choking				Hives/urticaria			
Wheezing				Calcium deposits			
Asthma				Ulcers on fingers/toes			
GENITOURINARY:				Using sunblock?			SPF #:
Genital Ulcers				**MUSCULOSKELETAL:**			
Difficulty Urinating				Joint Pain (list joints)			
RENAL:				Joint swelling (specify)			
Blood in urine				Lower back pain			
Fluid retention				Stiffness (how long)			
OTHER:				Muscle Pain			
				Weakness			
				Limp			
FEMALES ONLY: Are you currently on your Menstrual Period?			Date of LMP: _____	Difficulty w/ Daily Activities (Circle: sports, play, dressing, eating, writing/typing, stairs, other)			

Comments:_____

_____

_____

Does your child have any medication allergies?_____

(if so list reaction)_____

For IVIG/ Infusion patients only: (if N/A proceed to next section)

IVIG Infusion Medication

Any reactions?_____
Any issues with IV access or port?_____
Any vaccine challenges or titers redrawn? _____

Immunizations Up To Date? Yes or No (if No explain): _____ **Last Flu shot?** _____

Social History:
Lives with (check all that apply): Mother, Father, Grandparent, Guardian, Other_____
Siblings (and ages):_____
Grade in School: _____ Regular classes Hospital Homebound Home-schooled.
Avg. Grades:_____

Any recent travel in the past year (list where)?_____ Any camping or tick bites?_____

Any recent illnesses or known sick contacts?_____ Any Infectious exposures?_____

Any Sports?(specify any difficulties)_____

Are you missing school? (how often and why)_____ Any change in school grades? (why?)_____

Are you in counseling?_____ Any suicidal thoughts or attempts?_____

Are you sexually Active? _____ Use of birth control?_____ History of pregnancy or abortion?_____

Any history of Sexually Transmitted Diseases? (if so, please list:_____)

Drug use(please specify)?_____ Alcohol use (how much)?_____ Smoking (how much)?_____

Please complete the following if you are a New Patient or update if there have been any changes:

Past Medical History:_____
_____
_____
Birth hisotry:_____
Developmental issues:_____
Hospitalizations:_____

Surgical History: (list procedure and approximate date): _____
_____
_____

Family History: (Circle if +): Lupus, Rheumatoid arthritis, Ankylosing Spondylitis, Dermatomyositis, Scleroderma, Psoriasis, Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis), Fibromyalgia, Vasculitis, Wegener's, Pulmonary hemorrhage (bleeding into lungs), Blood Clots, Kidney Problems (circle if dialysis or transplant), Thyroid disease, Uveitis/Iritis, Sarcoidosis, Diabetes, Migraines, Recurrent miscarriages, Stroke or hear attack at young age, TB, Hepatitis, Immunodeficiency, Other:_____
_____