# CHILDREN'S HOSPITAL RHEUMATOLOGY PROGRAM NEW PATIENT HISTORY FORM

| **Name** | **Date of Birth** |
|---|---|
| **Pharmacy name:** | **Pharmacy Address:** |

**Please send a visit letter to:** o My child's pediatrician o Referring provider o Another physician:

**The problem or question that brought me/my child to the Boston Children's Hospital Rheumatology Program:**

**Prior testing or procedures related to this problem (e.g. blood tests, X-rays/scans, joint tap):**

**Symptoms have been present for:** 0-1 week_____ 2-4 weeks _____ 1-3months _____

6 months to 1 year _____ over 1 year _____

**Limp:** Yes_____ No_____

Laterality: right side_____ left side_____ unsure_____ refuses/unable to walk_____
Continuous (all the time)_____ Intermittent (off/on)_____

**Joint Swelling:** Yes_____ No_____
**If yes**, joint swelling is Continuous (**all the time**)_____ Intermittent (**off/on**)_____
How long have the swelling lasted? hours_____ days_____
Date the first swollen joint appeared _____
The joint(s) which were swollen first _____
Other joints which have become swollen _____

**Joint Pain:** Yes_____ No_____
**If yes**, the joint pain stays in the same joints during 1day: Yes_____ No_____
The pain is worst in the morning _____ at night _____ continuous _____ after activity _____ after rest _____
The pain wakes my child from sleep: Yes_____ No_____
How does your child **describe** the pain? _____
How long does the pain last? _____
What helps to relieve the pain? _____
What makes the pain worse? _____

**Joint Stiffness:** Yes_____ No_____
**If yes**, the joint stiffness is in the morning _____ at night _____ same _____ after activity _____ after rest _____
The stiffness lasts less than 30 minutes_____ 30-60 minutes_____ 1-2 hours_____ 2-4 hours_____

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**Fevers:** Yes_____ No_____
**If yes**, the fever is continuous (all the time)_____ intermittent (off/on)_____ periodic_____
How high is the fever? _____
When did the fevers start? _____
How many days does it last? Minimum:_____Maximum:_____Average:_____
How long is the interval between fevers? Minimum:_____Maximum:_____Average:_____
Any associated symptoms with fevers? Yes (if yes please explain)_____ No___
Are there any fever triggers? Yes (if yes please explain)_____No___
Is the fever predictable? Yes (please explain how? Based on timing or prodromal features?)_____No___
Are there any prodromal features of fever? Yes (please explain)_____No___
Was your child tested for infections during fever? Yes_____No___
Please specify positive infections._____

**Rash:** Yes_____ No_____
**If yes**, the rash is present only when symptoms occur_____ continuous _____ intermittent _____ with fever_____
The rash is on the face_____ chest_____ stomach_____ back_____ arms/legs _____
Describe rash: raised_____ not raised _____ color _____ does it itch? _____

**Others: Muscle weakness**: Yes_____ No_____ **Muscle pain:** Yes_____ No_____
**Joint cracking:** Yes_____ No_____ **Joint locking:** Yes_____ No_____
**Back pain:** Yes_____ No_____

**The symptoms occurred with or immediately after:**
**Trauma:** Yes_____ No_____ if yes, describe: _____
**Travel:** Yes_____ No_____ if yes, describe: _____
**Tick Bite:** Yes_____ No_____ if yes, describe: _____
**After an Illness:** Yes_____ No_____ if yes, cold/upper respiratory_____ Strep throat_____ stomach virus_____
Infectious mononucleosis_____ other_____

**The symptoms are preventing my child from doing normal activities:** Yes_____ No_____
**If yes,** during play _____ school _____ gym _____walking upstairs _____
other_____

**What medicines have you tried for your child's problem?**

| Medicine | Last time taken | Length of time on the medicine | Reason for stopping the medicine |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**What medicines is your child currently taking? (Please include vitamins, over the counter, birth control pills)**

| Medicine | Last time taken | Dose | Frequency per day | How well does it work? | | |
|---|---|---|---|---|---|---|
| | | | | Very Well | Just OK | Not at all |
| | | | | | | |
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**Is your child taking any alternative or homeopathic medicines? If yes, please list.**

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**Is your child allergic to medications or food? Please describe:**

**Was your child born o** Full-term o Premature o Via normal delivery o Via C-section o Requiring supplemental oxygen?

**Has your child had any other medical problems or diagnoses?**

_____

_____

_____

_____

**Has your child been hospitalized, had any surgeries, or fractures?**
**If yes, please describe_____**

**Are your child's immunizations up to date? o Yes o No**
**Did your child receive any recent immunization? o Yes o No**
**If yes please indicate which_____**

## SOCIAL HISTORY:

**Siblings and their ages _____**
**Mother's/Guardian's Occupation: _____**
**Father's/Guardian's Occupation: _____**

**Who are the legal guardians? o Mother o Father o Both o Other_____**
**Does your child attend school/daycare? o Yes o No**
**If yes: Current grade? _____ Number of days of missed school this year? _____**
**School Work:** o Outstanding o Satisfactory o Poor
**Your child participates in what types of sports/activities? _____**
**Alcohol/cigarette/Cannabis/Other substance use: _____**

**FAMILY HISTORY: Please indicate if the patient's parents, grandparents, or siblings have had any of the following conditions:**

| Condition | Relation to patient | Condition | Relation to patient |
|---|---|---|---|
| Crohn's Disease/ Ulcerative Colitis | | Lupus | |
| Celiac Disease | | Rheumatoid Arthritis | |
| Thyroid Disease | | Psoriasis | |
| Positive ANA | | Dermatomyositis | |
| Bleeding Disorders | | Gout | |
| Clotting Disorders | | Scleroderma | |
| Miscarriage | | Diabetes (childhood onset) | |
| Early age heart disease | | Recurrent infections | |
| Early age stroke | | Kidney problems | |
| Back problems | | Brain /nerve problems | |
| Eye problems | | Mouth/genital ulcers | |
| Recurrent tonsillitis | | Tonsillectomy | |
| Recurrent fevers | | Others | |

**o No family history of any of the above**

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**REVIEW OF SYSTEMS: Please indicate any problems in the following organ systems:**

Constitutional:
- Fever
- Fatigue
- Unexplained excessive weight loss or gain
- Muscle weakness

Eyes:
- Pain
- Redness
- Dryness
- Light sensitivity
- Vision problem
- Blurry vision

Ears-Nose-Mouth-Throat:
- Hearing difficulty
- Frequent nose bleeds
- Recurrent mouth sores
- Dry mouth
- Teeth or gum problems
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Cardiovascular:
- Chest pain
- Dizziness
- Increased heard beat
- Exercise intolerance
- Heart murmur

Respiratory:
- Shortness of breath
- Cough
- Wheezing

Gastrointestinal:
- Abdominal pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool

Genitourinary:
- Difficulty with urination
- Change in frequency
- Change in urine color
- Rash/ulcers

For females only:
date of last menstrual period: ____

Musculoskeletal:
- Morning stiffness
- Joint swelling
- Joint pain
- Muscle weakness
- Muscle pain

Skin and appendices:
- Skin rash
- Hives
- Nodules/Bumps
- Nail changes
- Hair loss
- Easy bruising
- Color changes of hands and feet

Endocrine:
- Excessive thirst
- Thyroid problems
- PCOS

NeuroPsychiatric:
- Headaches
- Sleep difficulties
- Numbness or tingling
- Muscle spasms
- Excessive worrying
- Anxiety
- Depressive symptoms
- OCD
- PTSD
- Substance use problems

Hematologic:
- Increased bruising
- Increased bleeding
- Problems with blood counts

Immunology/Allergy:
- Frequent infections requiring antibiotics
- Unexplained severe infections
- Allergies

**Reviewed by Provider**_____**Date**_____