

Dr. Shanley O’Brien, M.D.

*Rheumatologist*

**New Patient Form**

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient’s Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

*Please list any medications, including items such as Aspirin, Vitamins/Supplements, Laxatives, etc.*

Name Dosage/Strength Frequency How long have you taken this medication?

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**Do you have any Drug Allergies or Sensitivities?** **Yes \_\_\_\_\_\_ No \_\_\_\_\_\_**

***If yes****, please list the name of the medication and the reaction or side effect*

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**Rheumatologic (Arthritis) History**

*At any time, have you had any of the following?*

 Yes No

Arthritis (type unknown) **\_\_\_ \_\_\_**

Osteoarthritis **\_\_\_ \_\_\_**

Rheumatoid Arthritis **\_\_\_ \_\_\_**

Gout **\_\_\_ \_\_\_**

Lupus, or “SLE” **\_\_\_ \_\_\_**

Ankylosing Spondylitis **\_\_\_ \_\_\_**

Childhood Arthritis **\_\_\_ \_\_\_**

Osteoporosis **\_\_\_ \_\_\_**

**Medical History:**

*Please list any medical conditions and any significant illnesses not listed above*

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**Previous Surgeries:**

Date Type of Surgery

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**Family History:**

Mother \_\_\_ Living \_\_\_Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_ Living \_\_\_Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children \_\_\_Living \_\_\_ Deceased Age\_\_\_ If deceased, cause of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has a blood relative had any of the following illnesses?**

Rheumatoid Arthritis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lupus Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sjogren’s Syndrome Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vasculitis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scleroderma Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatomyositis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polymyositis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psoriatic Arthritis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ankylosing Spondylitis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inflammatory Bowel Disease Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reactive Arthritis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoarthritis Yes or No Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Marital Status: Married \_\_\_\_\_\_ Divorced \_\_\_\_\_\_ Never Married \_\_\_\_\_\_

Are you currently a tobacco user? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? Cigarettes \_\_\_ Vape\_\_\_ Chew\_\_\_

Are you a former tobacco user? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when did you quit? Year \_\_\_\_\_\_ Month \_\_\_\_\_

Do you consume alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_ How many drinks? \_\_\_\_\_\_\_\_

Do you use marijuana? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how often? \_\_\_\_\_ Edible? \_\_\_\_\_ Inhaled? \_\_\_\_\_