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

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**_____