### CHILDREN’S HOSPITAL RHEUMATOLOGY PROGRAM NEW PATIENT HISTORY FORM

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy name:</th>
<th>Pharmacy Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please send a visit letter to:**  
- My child’s pediatrician  
- Referring provider  
- 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
- 1-3 months
- 6 months to 1 year
- Over 1 year

**Limp:**
- Yes
- No

**Laterality:**
- Right side
- Left side
- Unsure
- Refuses/unable to walk

**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 1 day:
- 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 [ ]

---

Adopted from intake form by Fatma Dedeoglu, MD by by Olha Halyabar, MD, last revised 07/02/2020
**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______  

- **Joint cracking:** Yes______ No______  

- **Muscle pain:** 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?**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Last time taken</th>
<th>Length of time on the medicine</th>
<th>Reason for stopping the medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Last time taken</th>
<th>Dose</th>
<th>Frequency per day</th>
<th>How well does it work?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very Well</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is your child taking any alternative or homeopathic medicines?** If yes, please list.
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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relation to patient</th>
<th>Condition</th>
<th>Relation to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crohn’s Disease/ Ulcerative Colitis</td>
<td></td>
<td>Lupus</td>
<td></td>
</tr>
<tr>
<td>Celiac Disease</td>
<td></td>
<td>Rheumatoid Arthritis</td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td></td>
<td>Psoriasis</td>
<td></td>
</tr>
<tr>
<td>Positive ANA</td>
<td></td>
<td>Dermatomyositis</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td></td>
<td>Gout</td>
<td></td>
</tr>
<tr>
<td>Clotting Disorders</td>
<td></td>
<td>Scleroderma</td>
<td></td>
</tr>
<tr>
<td>Miscarriage</td>
<td></td>
<td>Diabetes (childhood onset)</td>
<td></td>
</tr>
<tr>
<td>Early age heart disease</td>
<td></td>
<td>Recurrent infections</td>
<td></td>
</tr>
<tr>
<td>Early age stroke</td>
<td></td>
<td>Kidney problems</td>
<td></td>
</tr>
<tr>
<td>Back problems</td>
<td></td>
<td>Brain /nerv e problems</td>
<td></td>
</tr>
<tr>
<td>Eye problems</td>
<td></td>
<td>Mouth/genital ulcers</td>
<td></td>
</tr>
<tr>
<td>Recurrent tonsillitis</td>
<td></td>
<td>Tonsillectomy</td>
<td></td>
</tr>
<tr>
<td>Recurrent fevers</td>
<td></td>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

o No family history of any of the above

Adopted from intake form by Fatma Dedeoglu, MD by Olha Halyabar, MD, last revised 07/02/2020
CHILDREN’S HOSPITAL RHEUMATOLOGY PROGRAM NEW PATIENT HISTORY FORM

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

**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

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

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

Reviewed by Provider_____________________________ Date_____________________

Adopted from intake form by Fatma Dedeoglu, MD by Olha Halyabar, MD, last revised 07/02/2020