CUEVAS CENTER
For Arthritis & Fibromyalgia

Patient Name: _____ Date: _____

Reason for today's visit? _____

Brief description of how your problem started and has progressed to date.

_____
_____
_____
_____
_____
_____
_____

Pain level today is (circle) 1 2 3 4 5 6 7 8 9 10
Pain is described as (circle) sharp dull stabbing burning aching shooting throbbing
Worst time of is (circle) morning midday evening
Morning stiffness lasts (circle) < 30min 30-60min > 60min
What makes you feel better? _____
What makes you feel worse? _____
Have you had? (circle) fluid around heart or lung, mouth sores, rash in the sun, low blood counts, blood or protein in the urine, seizures, numbness/tingling, fatigue, unexplained fever, hair loss, red eye(s), psoriasis, bloody diarrhea)

Personal Medical History: (circle)

Rheumatoid arthritis	Lupus	Vasculitis	Osteoarthritis	Psoriasis	Psoriatic arthritis
Ankylosing spondylitis	Gout	Fibromyalgia	Heart attack	Heart failure	Psoriasis
Ulcerative colitis	Crohn's	Neck pain	Fibromyalgia	Osteoporosis	Diabetes
Sleep apnea	PTSD	Depression	Anxiety	Addiction	Thyroid disease
Hepatitis B or C	Cancer	TB or +PPD	Multiple sclerosis	Stomach ulcer	Gastric bypass

Other: _____

Past Surgical History: (list all surgeries)

_____ _____
_____ _____
_____ _____

Allergies: (list all medications that you are allergic to and the reaction)

_____
_____
_____
_____

Are you allergic to Latex? Yes / No

Are you allergic to gluten? Yes / No / Maybe

Medications: (list name of medication & dose/frequency)

Example: Lyrica 100mg twice a day

Family history: (circle if you have a blood relative with any of the following)

Rheumatoid arthritis	Lupus	Gout	Osteoarthritis	Psoriasis	Psoriatic arthritis
Ankylosing Spondylitis	Heart disease	Addiction	Depression	Anxiety	Fibromyalgia
Osteoporosis	Multiple sclerosis	Thyroid disease	Cancer	Crohn's	Ulcerative colitis

Other: _____

Social History:

Do you smoke cigarettes? Yes / No
Do you drink more than 2 alcoholic beverages a week? Yes / No
Do you use marijuana? Yes / No
Do you have history of drug or alcohol dependence? Yes / No
Do you exercise at least once a week? Yes / No
Is there any chance of becoming pregnant (or if male impregnating your partner)? Yes / No
Employment? _____
Are you applying for (or already on) disability? Yes / No

Review of systems: (circle symptoms present in past 2 weeks)

GENERAL
Recent weight gain; Recent weight loss; Fatigue; Weakness; Fever; Night sweats

NECK/THROAT
Frequent sore throats; Hoarseness; Difficulty in swallowing; Pain in jaw while chewing; Swollen glands; Tender glands

HEART AND LUNGS
Pain in chest; Irregular heart beat; Sudden changes in heart beat; Shortness of breath; Swollen legs or feet; Cough; Coughing of blood

STOMACH AND INTESTINES
Nausea; Heartburn; Stomach pain relieved by food; Vomiting of blood/"coffee grounds"; Yellow jaundice; Increasing constipation; Persistent diarrhea; Blood in stools; Black stools

MUSCLE/JOINTS/BONES
Morning stiffness lasting over an hour; Joint pain; Muscle weakness; Joint swelling

EARS
Ringing in ears; Loss of hearing; Red/Swollen ear

EYES
Pain; Redness; Loss of vision; Double or blurred vision; Dryness; Feels like something in eye

MOUTH AND NOSE
Sore tongue; Bleeding gums; Sores in mouth; Loss of taste; Dryness; Recent increase in tooth cavities; Nosebleeds; Loss of smell

KIDNEY/URINE/BLADDER
Difficult urination; Pain or burning on urination; Blood in urine; Discharge from penis/vagina Vaginal dryness; Genital ulcers

SKIN
Tightness of skin; Rash on body, Facial rash, Color change of hands in cold, sun sensitivity, hair loss

NERVOUS SYSTEM
Headache, numbness/tingling of hands/feet

GYNECOLOGY
history of miscarriage

PSYCHIATRIC
Depression, Anxiety, Increased Stress, Suicidal Thoughts