Midtown Office
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Suite 600
Charlotte, NC 28207

AOCC Arthritis & Osteoporosis Consultants of the Carolinas

Ballantyne Office
7810 Ballantyne Commons Parkway
Suite 300
Charlotte, NC 28277

New Patient Form

Name_____
Name of referring physician _____
Gender at Birth _____
Current Gender Identity _____

Date of Birth _____
Primary Care Physician _____
Approximate Last Visit _____

Reason for your visit today _____

_____

Current medications: _____

_____

_____

_____

_____

_____

Name of Practitioners seen in last 5 years (Names of doctors)

_____

_____

ALLERGIES (medication and reaction)_____

_____

_____

When did your symptoms begin- approximately _____

Please describe your Rheumatologic symptoms _____

_____

_____

_____

Prior Diagnosis of your symptoms _____

Previous Treatments for this problem (physical therapy, medications etc.)

_____

_____

Pharmacy Information

_____

_____

_____

_____

IMP#004

Past Medical History: (check if you have had)

☐ Alcoholism	☐ Cancer	☐ Hepatitis	☐ Diverticulitis	☐ Systemic lupus
☐ Anemia	☐ COPD	☐ High blood pressure	☐ Tuberculosis	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Shingles	☐ Psoriasis
☐ Asthma	☐ Diabetes	☐ Osteoporosis	☐ Stomach Ulcer	☐ Gout
☐ Blood Clots	☐ Heartburn	☐ Thyroid trouble	☐ Fracture	

☐ Other- Please list below

_____

Past Surgical History:

Year	Hospitalization or Surgery	Year	Hospitalization or Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Obstetrical history: Age at first period _____Age of last period (menopause) ____Hysterectomy ☐ Yes ☐ No Ovaries Removed? ☐ Yes ☐ No
# of Pregnancies _____ # of abortions _____ # of miscarriages_____ # of living children _____

Family History:

At any point has a blood relative had any of the following: (check those that apply)

	Mother	Father	Sibling	Grandparent	Aunt/Uncle	Child
Alcoholism						
Arthritis						
Bleeding disorder						
Cancer						
Heart Attack						
Diabetes						
High Cholesterol						
High Blood pressure						
Stroke						
Osteoporosis						
Ankylosing Spondylitis						
Behcet's						
Crohn's Disease/ Ulcerative Colitis						
Lupus						
Psoriasis/ psoriatic arthritis						
Hip Fracture						
Other (list)						

Mother living ? ☐ Yes ☐ No Cause of death? _____
Father living ? ☐ Yes ☐ No Cause of death? _____

Social History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Occupation/ Prior jobs _____

Who lives at home with you? _____

Habits:
Have you ever smoked? ☐ Yes ☐ No How many packs/ day? ____ How many years? ___ Quit? ___ years
Have you ever used a vaping device? ☐ Yes ☐ No With Nicotine? ☐ Yes ☐ No

Any other tobacco use? _____
Do you drink alcohol ☐ Yes ☐ No How often? _____ How much? _____
Do you exercise? ☐ Yes ☐ No How often? _____ How much? _____
Are you at risk of HIV infection? ☐ Yes ☐ No

Yes	No	Check each Item	Yes	No	Check each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
		GENERAL			**HEART**			**METABOLIC**			**SKIN**
		Chills			Chest pain			Cold intolerance			Bruising
		Fatigue			Leg pain with walking			Hair loss			Discoid rash
		Fever			Lower extremity swelling			Heat intolerance			Hives
		Night Sweats			Fingers turning white, blue or red			Excess hair growth			Nail changes
		Weight gain			Fast heart rate			Hot flashes			Sensitivity to the sun
		Weight Loss			Varicose veins			Increased thirst			Psoriasis
		Eyes, Ears and mouth			**GASTROINTESTINAL**			**NEUROLOGIC**			Rash
		Vision changes			Abdominal pain			Confusion/ disorientation			Scalp tenderness
		Vision loss			Bloating			Dizziness			**Musculoskeletal**
		Dental cavities			Blood in stools			Extremity numbness			Back pain
		Double vision			Constipation			Extremity weakness			Height loss
		Dry mouth			Diarrhea			Changes in gait			Joint pain
		Dry eyes			Difficulty swallowing			Headache			Joint swelling
		Nose bleeds			Heartburn			Memory loss			Joint tenderness
		Hearing loss			Loss of appetite			Seizures			Low back pain
		Hoarseness			Nausea			Fainting			Morning stiffness
		Jaw pain			Vomiting			Tingling			Muscle cramping
		Nose sores			**GENITOURINARY**			Tremors			Muscle weakness
		Mouth sores			Genital ulcers			**PSYCHIATRIC**			Muscle pain
		Red eye			Blood in urine			Anxiety			Neck pain
		Sinus infections			Kidney stones			Depression			Neck stiffness
		RESPIRATORY			Urination at night			Worry			**BLOOD**
		Sleep apnea			Pelvic pain			Insomnia			Easy bruising
		Cough			Scrotum or testicular pain			**IMMUNOLOGIC**			Easy bleeding
		Frequent respiratory infections			Urinary frequency			Allergic Rhinitis			Enlarged lymph nodes
		Coughing up blood			Urinary incontinence			Frequent infections			
		Chest pain with deep breaths						Food allergies			
		Shortness of breath									

Please check any symptoms that you have had in the past (outside of an acute infection)

Other (Please list) _____

_____