Helen Feng,MD
2242 Camden Ave, Ste. 200
San Jose, CA 95124
P: 408-963-6359 F: 408-963-6761

Today's Date_____
Name:_____**DOB:**_____**AGE**_____
Accompanied by: _____

Who is your PCP(Primary care doctor)?_____
When was your last visit (Date)?_____

Reason for visit? Pertaining to Rheumatology only. (e.g. – Follow up, Discuss Labs/Xray results, knee injection, New prescriptions, medication refill, etc)

1.
2.
3.

Do you have any trouble taking any of the medications Dr. Feng has prescribed?

_____

Drug Allergy:_____
Other Allergy: (e.g: Food, Environmental):_____

Pain Scale 0-10(10 is the most)_____ **Which part of the body?**_____
Do you have morning stiffness? Yes___**No**___**If yes, how long does it last**_____
Do you smoke? Yes___**How often:**_____ **No, Never, Quit? When?**_____
Do you drink Alcohol? Yes____ **No** ____ **If yes, how often?**_____
Do you have diabetes? Yes____**No** ____
Do you have high blood pressure? Yes____**No**_____
Do you have heart disease? Yes _____**No**_____
Are you Pregnant? Yes_____ **No**_____

Check all vaccines that you received and date of vaccination.
_____**Flu Shot – Date**_____
_____**New Pneumonia (Prevnra 13) – Date**_____
_____**Old Pneumonia (Pneumovax 23) – Date**_____
_____**T-dap = Whooping cough+tenuous shot – Date**_____
_____**Zoster Vaccination (Shingle shot) – Date**_____

Have you been to the emergency room, hospital or any other provider since your last visit?
YES / NO. If yes, please describe reason for hospitalization.

For Office Use Only
Vital signs: BP_____/_____P_____T_____Wgt_____Lbs Ht_____

Gait_____Walking Aid_____

Patient Diagnosis_____

Please inform the front desk staff of any changes of address, phone number, or insurance carrier.

What brings you in to see the doctor today?

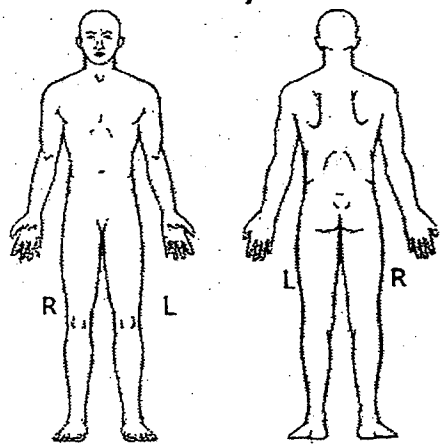
Name:

DOB:

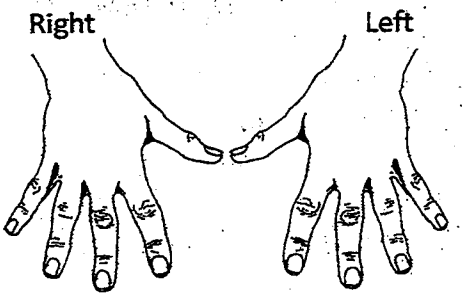
DATE:

Where do you have pain (please shade in affected areas)?

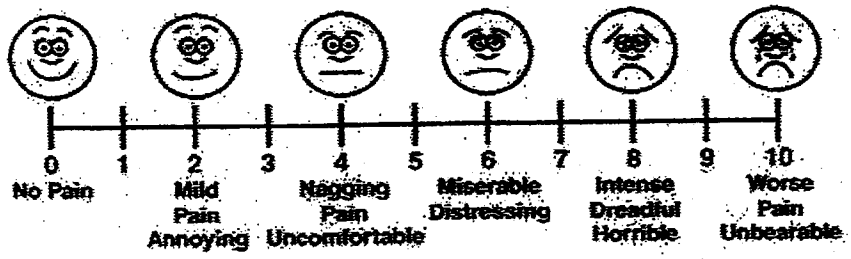
Body:



Hands:



How severe has your pain been in the last few days?



How Long has the pain been there?_____

Pain feels: □ sharp □ dull □ burning □ achy □ electric

Pain is most severe in the: □ morning □ mid-day □ evening □ night □ after activity □ random □ constant

What makes your pain feel better?

Over the past couple of weeks, have any of the following symptoms concerned you?

□ fever
□ sweats
□ more than 5 lbs weight loss
□ red eyes
□ dry eyes
□ dry mouth
□ difficulty swallowing
□ vomiting
□ ulcers in the mouth
□ chest pain
□ shortness of breath
□ cough
□ palpitations
□ nausea
□ blood in the stool
□ black stool
□ severe frequent headaches
□ vision changes
□ pain with urination
□ diarrhea
□ fingers turning funny colors in the cold
□ skin rash with sun exposure
□ fatigue
□ sleep problems
□ brain fog
□ swollen lymph nodes
□ allergies
□ depression
□ difficulty rising from a chair due to weakness

□ *none of the above*

We greatly appreciate your filling this form out at each visit. It helps us provide you with the excellent care you deserve. Thank you!