Dr. C Lyddell
RHEUMATOLOGIST

New Patient Form

Patient Information

Name:
First: Last:

Date of Birth (mm/dd/yyyy):

Gender:
Male
Female
Other:

Marital Status:

Single	Widowed
Married	Divorced
Common-law	Separated

Number of Children:

Occupation:

Are you on Disability?
Yes No

Contact Information

Street Address:
Address Line 2:
City: **Province:** Alberta **Postal Code:**
Phone:
Email:

Drug Plan and Pharmacy

What is your Drug Plan?

- ☐ Private Insurance
- ☐ Over 65 Government
- ☐ Blue Cross
- ☐ Other:

Pharmacy Name:

Pharmacy Address:
Street Address:
Address Line 2:
City: Province: Alberta Postal Code:

Pharmacy Phone:

Pharmacy Fax:

Family Doctor Information

Family Doctor Name:
First: Last:

Family Doctor Contact Information:
Street Address:
Address Line 2:
City: Province: Alberta Postal Code:
Phone:

Medical History

Reason for Visit

Why are you seeing the Doctor today?

Past Medical History - Problems

Do you have or have you had any problems relating to your:

- ☐ Eyes
- ☐ Nose
- ☐ Thyroid
- ☐ Throat
- ☐ Heart
- ☐ Pregnancy (miscarriage)
- ☐ Stomach
- ☐ Bones
- ☐ Muscles
- ☐ Mouth/Jaw
- ☐ Chest
- ☐ Bowels
- ☐ Joints
- ☐ Head/Brain

Past Medical History - Illnesses

Do you have or have you had any of the following illnesses?

- ☐ Heart Attack/Angina
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Crohn's/Ulcerative Colitis
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Tuberculosis
- ☐ Depression
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ TIA/Stroke
- ☐ Haemochromatosis
- ☐ Hepatitis

Other:

Stomach Ulcer or Bleeding

Have you ever had a Stomach Ulcer or Bleeding?

- ☐ Yes
- ☐ No

How was it diagnosed?

- ☐ Scope
- ☐ Barium X-ray
- ☐ Don't Know

Surgeries/Operations

Have you ever had any surgeries/operations?

- ☐ Yes
- ☐ No

Medications

Please list any prescription or non-prescription MEDICATIONS you are taking now:

Medication Name	Dose / Amount	How Often

What NSAIDs have you tried?

- ☐ Celebrex
- ☐ Mobicox
- ☐ Naprosyn
- ☐ Arthrotec
- ☐ Advil/Motrin
- ☐ Indocid
- ☐ Voltaren
- ☐ Feldene

Allergies

Do you have any ALLERGIES to Medications?

- ☐ Yes
- ☐ No
- ☐ If Yes, please list:

Lifestyle

Do you SMOKE cigarettes?

- ☐ Never
- ☐ Used to, but quit
- ☐ Yes, still do

Do you drink Alcohol?

- ☐ Yes
- ☐ No

  If Yes, how often and how much?

Family History

Do any of your immediate family or distant family relatives have any of the following?

- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Gout
- ☐ Blood clots
- ☐ Raynaud's Phenomenon
- ☐ Osteoarthritis
- ☐ Other types of Arthritis
- ☐ Psoriasis
- ☐ Cancer
- ☐ Bleeding problems
- ☐ Low Back Pain
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Diabetes

Pain Diagram

Please choose option number corresponding with the following diagram to show where you have had pain over the past month.