



This document should be shared with and carried by young adults and caregivers.

Date Completed/Last Revised:

**Contact Information**

Name:		Nickname:	
DOB:		Preferred Language:	
Parent (Caregiver):		Relationship:	
Address:			
Cell #:	Home #:	Best Time to Reach:	
E-Mail:		Best Way to Reach:	Text Phone Email
Health Insurance/Plan:		Group and ID #:	

**Additional Information** (hobbies/interests, personal details, other key information):

**SLE History**

**Date of SLE Diagnosis:**

SLE Manifestations History:	Renal Disease:	Other Complications
<input type="checkbox"/> Malar rash <input type="checkbox"/> Discoid rash <input type="checkbox"/> Other rash <input type="checkbox"/> Alopecia <input type="checkbox"/> Oral/nasal ulcers <input type="checkbox"/> Pleural effusion/pleurisy <input type="checkbox"/> Pericardial effusion/pericarditis <input type="checkbox"/> Interstitial lung disease <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Polyarthritis <input type="checkbox"/> Myositis <input type="checkbox"/> Enteritis <input type="checkbox"/> Leukopenia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Hemolytic anemia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Leukopenia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Hemolytic anemia <input type="checkbox"/> Hemolytic anemia <input type="checkbox"/> Leukopenia	<input type="checkbox"/> No history of renal <input type="checkbox"/> Renal biopsy performed Date(s): _____ <input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV <input type="checkbox"/> Class V <input type="checkbox"/> Class VI <input type="checkbox"/> Thrombotic microangiopathy  <input type="checkbox"/> On dialysis <input type="checkbox"/> S/p renal transplant	<input type="checkbox"/> Cerebritis <input type="checkbox"/> Stroke <input type="checkbox"/> Transverse myelitis <input type="checkbox"/> Cognitive dysfunction <input type="checkbox"/> Psychosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Other:
	<b>Other History/Complications:</b> <input type="checkbox"/> DVT/PE <input type="checkbox"/> Avascular necrosis <input type="checkbox"/> Anti-phospholipid antibody syndrome <input type="checkbox"/> Raynaud's <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Current hypertension <input type="checkbox"/> Macrophage activation syndrome  <input type="checkbox"/> Pregnancy <input type="checkbox"/> Abnormal bone density testing <input type="checkbox"/> Cataract <input type="checkbox"/> Sjogren's <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> Other	

Currently Active SLE Problems:	SLE Lab History		
	Ever Present	Absent	Not Done
	ANA		
	Anti-dsDNA/crithidia		
	Low C3		
	Low C4		
	Anti-Smith antibody		
	Anti-RNP antibody		
	Anti-SSARo antibody		
	Anti-SSB/La antibody		
	Anti-cardiolipin IgG/ IgM		
	Anti-beta2-glycoprotein 1 IgG/IgM		
	Lupus anticoagulant		
	Low vitamin D-25		

**Current Medications**  See attached medication list



		Preferred pharmacy:
Medication	Dose	Frequency
<b>Prior SLE Medications</b>		Reason Discontinued
<input type="checkbox"/> Cyclophosphamide IV	Cumulative dose _____ grams	
<input type="checkbox"/> Cyclophosphamide po	Cumulative dose _____ grams	
<input type="checkbox"/> Mycophenolate mofetil (Cellcept)		
<input type="checkbox"/> Mycophenolic acid (Myfortic)		
<input type="checkbox"/> Azathioprine (Imuran)		
<input type="checkbox"/> Methotrexate		
<input type="checkbox"/> Leflunomide (Arava)		
<input type="checkbox"/> Belimumab (Benlysta)		
<input type="checkbox"/> Rituximab (Rituxan)		
<input type="checkbox"/> Cyclosporine (Neoral, Sandimmune)		
<input type="checkbox"/> Tacrolimus (Prograf)		
<input type="checkbox"/> Hydroxychloroquine (Plaquenil)		
<input type="checkbox"/> Other		
<b>Medication Allergy/Intolerance</b> <input type="checkbox"/> See attached list		
Medication	Reactions	
<b>Other Health Conditions, Key Surgeries, Procedures, Hospitalizations</b> <input type="checkbox"/> See attached list		
Condition/Surgery/Procedure/Hospitalization	Details	
<b>Important Immunizations</b> <input type="checkbox"/> See attached immunization list		Date(s)
<input type="checkbox"/> Pneumococcal vaccination		
<input type="checkbox"/> Influenza vaccination		
<input type="checkbox"/> Meningococcal vaccination		
<b>Most Recent Key Labs and Radiology</b> <input type="checkbox"/> See attached lab and radiology results		
Test	Date	

<b>Social History</b>			
Lives with:	Educational/vocational goals:		
<b>Risk Behaviors:</b>	Yes	No	Not Asked
Uses alcohol			
Uses tobacco			
Uses other drugs			
Discussed sexual activity, reproductive health, contraception			
Discussed contraception			
<b>Other Health Care Providers</b>			
<b>Type</b>	<b>Name</b>	<b>Phone</b>	<b>Fax</b>
Primary Care			
Eye Provider			
<b>Emergency Care Plan</b>			
Emergency contact name:			
Relationship:	Phone 1:	Phone 2:	
Preferred location for emergency care:			
Special concerns for emergencies:			

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Patient/Guardian Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

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Rheumatology Provider Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

