

RHEUMATOLOGY ASSOCIATES P.C.

DATE: / /	Have you been treated by one of our doctors before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when _____
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PATIENT INFORMATION (PLEASE PRINT)

Patient Name:			Referred By:		
Address:			Date of Birth: / /		
City:	State:	Zip:	Social Security No.		
Home Phone: ()	Primary Y / N	Work Phone: ()	Cell Phone: ()	Primary Y / N	
E-mail Address: _____					
Please check if you do NOT have an e-mail address: _____					
(We will NOT e-mail you. This is for Patient Portal Messaging only.)					
Race (please circle): White Black Asian Indian/Alaskan Pac. Isle Other/Multi:					
Ethnicity (please circle): Hispanic Non-Hispanic Language:					
Patient's Employer:					
Employer's Address:					
Spouse's Employer:					
Responsible Party:			Relationship:		

INSURANCE INFORMATION

PRIMARY Insurance Company	Contract Number
Policy Holder Name	Group Number
SECONDARY Insurance Company (If applicable)	Contract Number
Policy Holder Name	Group Number

If insurance is Preferred Care, Health Choice, Southeast, or Partners PPO, what is the copay amount? \$ _____

Are you Retired? Yes No Is your spouse Retired? Yes No

Are you being seen because of an auto accident or an on-the-job injury? Yes No

We request payment at the time of service. You will be given an itemized statement for insurance purposes. If we participate with your insurance plan, you are required to pay your copayment and / or deductible at the time of service. We do participate with Medicare. I give my permission to release any and / or all information contained in my chart necessary to process my insurance claims.

Signature of Patient or Responsible Party _____ Date _____

Rheumatology Associates P.C.

Patient Contact Information

Patient Name _____

Date of Birth _____

Please list a secure phone number to leave voice messages.

Home phone # () _____

Cell phone # () _____

Please check this box, if you do not want us to leave a voice mail message.

Name of person to notify in case of emergency not living in your home.

1. _____
Name Relationship

Home phone # () _____

Cell phone # () _____

2. _____
Name Relationship

Home phone # () _____

Cell phone # () _____

Additional Contacts

Please update every six months.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that, as part of my health care, Rheumatology Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to effect treatment, payment or health care operations.

I understand that Rheumatology Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Rheumatology Associates reserves the right to change their notice and practices prior to implementation and in accordance with Section 164.520 of the Code of Federal Regulations. Should Rheumatology Associates change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand RHEUMATOLOGY ASSOCIATES is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of RHEUMATOLOGY ASSOCIATES, or any other individual listed below to disclose my protected health information as described on this form to the recipients below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Description of the information to be used or disclosed:

The patients entire medical record

Medical Data/ Information as related to:

- Specific condition(s): _____
- Specific professional service(s): _____
- Specific medication(s): _____
- Other: _____

Purpose of this information: Continued Health Care

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information:

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

This authorization is to be used for our own use, and RHEUMATOLOGY ASSOCIATES will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has a right to revoke this authorization. In order for the revocation of this authorization to be effective, RHEUMATOLOGY ASSOCIATES must receive the revocation in writing.

I fully understand and accept the terms of this authorization.

Patient's Signature

Date



NAME: _____

AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Form

Date of first appointment: ____/____/____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: ____/____/____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: F M
STREET APT#

CITY STATE ZIP Telephone: Home (____) _____
Work (____) _____

MARITAL STATUS: Never Married Married Divorced Separated Widowed

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) Self Family Friend Doctor Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? Yes No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

Please list the names of other practitioners you have seen for this problem:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself	Relative Name/Relationship	Yourself	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis
Other arthritis conditions: _____			

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

LEFT RIGHT LEFT RIGHT LEFT RIGHT

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffinated beverages?
 Cups/glasses per day? _____

Do you smoke? Yes No Past – How long ago? _____

Do you drink alcohol? Yes No Number per week _____

Has anyone ever told you to cut down on your drinking?
 Yes No

Do you use drugs for reasons that are not medical? Yes No
 If yes, please list: _____

Do you exercise regularly? Yes No
 Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? No Yes Describe: _____

Any other serious injuries? No Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Psoriasis _____ | |

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropracty, magnets, massage, over-the-counter preparations, etc.)

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram ___/___/___ Date of last eye exam ___/___/___ Date of last chest x-ray ___/___/___

Date of last Tuberculosis Test ___/___/___ Date of last bone densitometry ___/___/___

Constitutional

- Recent weight gain amount
Recent weight loss amount
Fatigue
Weakness
Fever

Eyes

- Pain
Redness
Loss of vision
Double or blurred vision
Dryness
Feels like something in eye
Itching eyes

Ears-Nose-Mouth-Throat

- Ringing in ears
Loss of hearing
Nosebleeds
Loss of smell
Dryness in nose
Runny nose
Sore tongue
Bleeding gums
Sores in mouth
Loss of taste
Dryness of mouth
Frequent sore throats
Hoarseness
Difficulty in swallowing

Cardiovascular

- Pain in chest
Irregular heart beat
Sudden changes in heart beat
High blood pressure
Heart murmurs

Respiratory

- Shortness of breath
Difficulty in breathing at night
Swollen legs or feet
Cough
Coughing of blood
Wheezing (asthma)

Gastrointestinal

- Nausea
Vomiting of blood or coffee ground material
Stomach pain relieved by food or milk
Jaundice
Increasing constipation
Persistent diarrhea
Blood in stools
Black stools
Heartburn

Genitourinary

- Difficult urination
Pain or burning on urination
Blood in urine
Cloudy, "smoky" urine
Pus in urine
Discharge from penis/vagina
Getting up at night to pass urine
Vaginal dryness
Rash/ulcers
Sexual difficulties
Prostate trouble

For Women Only:

- Age when periods began:
Periods regular? Yes No
How many days apart?
Date of last period?
Date of last pap?
Bleeding after menopause? Yes No
Number of pregnancies?
Number of miscarriages?

Musculoskeletal

- Morning stiffness
Lasting how long? Minutes Hours
Joint pain
Muscle weakness
Muscle tenderness
Joint swelling
List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- Easy bruising
Redness
Rash
Hives
Sun sensitive (sun allergy)
Tightness
Nodules/bumps
Hair loss
Color changes of hands or feet in the cold

Neurological System

- Headaches
Dizziness
Fainting
Muscle spasm
Loss of consciousness
Sensitivity or pain of hands and/or feet
Memory loss
Night sweats

Psychiatric

- Excessive worries
Anxiety
Easily losing temper
Depression
Agitation
Difficulty falling asleep
Difficulty staying asleep

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen glands
Tender glands
Anemia
Bleeding tendency
Transfusion/when

Allergic/Immunologic

- Frequent sneezing
Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: No Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, *how long* you were taking the medication, the *results* of taking the medication and list any *reactions* you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Circle any you have taken in the past</p> <p> Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisilicylate) Vioxx (rofecoxib) Voltaren (diclofenac) </p>					
Pain Relievers					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disease Modifying Antirheumatic Drugs (DMARDs)					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax) [®]		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

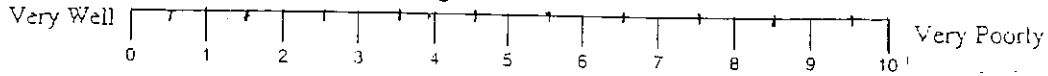
Have you participated in any clinical trials for new medications? Yes No

If yes, list:

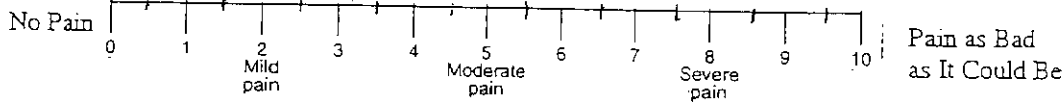
AMERICAN COLLEGE OF RHEUMATOLOGY

Patient Assessment

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:



How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:



Please answer the following questions, even if you feel that they may not be related to you at this time. Answer exactly as you think or feel – there are no right or wrong answers. Check the one best answer for each question.

Activity Level

Right now, are you able to:

	Without any difficulty	With some difficulty	With much difficulty	Unable to do
1. Dress yourself, including tying shoelaces and doing buttons?	_____0	_____1	_____2	_____3
2. Get in and out of bed?	_____0	_____1	_____2	_____3
3. Lift a full cup or glass to your mouth?	_____0	_____1	_____2	_____3
4. Walk outdoors on flat ground?	_____0	_____1	_____2	_____3
5. Wash and dry your entire body?	_____0	_____1	_____2	_____3
6. Bend down to pick up clothing from the floor?	_____0	_____1	_____2	_____3
7. Turn regular faucets on and off?	_____0	_____1	_____2	_____3
8. Get in and out of a car, bus, train or airplane?	_____0	_____1	_____2	_____3
9. Walk two miles?	_____0	_____1	_____2	_____3
10. Participate in sports and games as you like?	_____0	_____1	_____2	_____3
<hr/>				
11. Get a good night's sleep?	_____0	_____1.1	_____2.2	_____3.3
12. Deal with feelings of anxiety or being nervous?	_____0	_____1.1	_____2.2	_____3.3
13. Deal with feelings of depression or feeling blue?	_____0	_____1.1	_____2.2	_____3.3

For Office Use Only

GL

PN

FN

1=0.33
2=0.67
3=1.0
4=1.33
5=1.67
6=2.0
7=2.33
8=2.67
9=3.0
10=3.33
11=3.67
12=4.0
13=4.33
14=4.67
15=5.0
16=5.33
17=5.67
18=6.0
19=6.33
20=6.67
21=7.0
22=7.33
23=7.67
24=8.0
25=8.33
26=8.67
27=9.0
28=9.33
29=9.67
30=10.0

Your Name _____ Today's Date _____ Time of Day _____

Instructions for Office Staff

Activity Level Index Scoring: For FN (questions 1-10) add total points and convert using scale on right. For PS (questions 11-13), add total points.

Visual Analog Scales: measure with metric ruler. Line is exactly 10 cm long. Scores should be recorded in cm.mm format.

Adapted from Pincus T, Swearingen C, Wolfe F. Toward a Multidimensional Health Assessment Questionnaire. Arthritis Rheum 1999; 42:2220-2230.

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