RA RHEUMATOLOGY ASSOCIATES

Dear Patient:

We are delighted that you have chosen our practice for your care and we look forward to your visit.

Please make sure to arrive at least 30 minutes prior to your appointment time to allow us sufficient time to process your paperwork. Please arrive 15 minutes prior to your appointment time for future follow-up appointments.

In order to expedite our check-in process, please complete the enclosed paperwork prior to your appointment. When you arrive at our office for your appointment, please present your completed paperwork, proper identification such as a driver's license and all insurance cards.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to see you if a referral is not on file with our office by the scheduled appointment date.

For your convenience we accept cash, Master Card, Visa, American Express, Discover and/or personal checks for payment of your co-pay or co-insurance amount.

For more information about our practice, please visit us on the web at www.dfwra.com.

Rheumatology Associates

Effective Date of this Notice: April 9, 2003

RHEUMATOLOGY ASSOCIATES

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Practice Manager, 8144 Walnut Hill Lane, Ste. 800, Dallas, TX 75231

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to

provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Practice Manager, 214-540-0700** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Practice Manager, 214-540-0700**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Practice Manager, 8144 Walnut Hill Lane, Ste. 800, Dallas, TX 75231** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Practice Manager, 8144 Walnut Hill Lane, Ste. 800, Dallas, TX 75231**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request

(and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Practice Manager, 8144 Walnut Hill Lane, Ste. 800, Dallas, TX 75231**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Practice Manager, 214-540-0700**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Practice Manager, 214-540-0700**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Practice Manager, 214-540-0700.**

RA RHEUMATOLOGY ASSOCIATES

No Show/Cancellation Policy

Policy

Patients are expected to keep scheduled appointments. If they wish to cancel their appointment, they should contact our office no later than 24 hours prior to their appointment time. (Exception: Notification for cancellation of Monday appointment should be given no later than 12:00 pm on the Friday before the appointment)

Definition of a No-Show

A scheduled appointment for which a patient did not show up at the appropriate office prior to the appointment time and 24 hour advanced notice was not given.

RA RHEUMATOLOGY ASSOCIATES

Name _____
Cell # _____
E-Mail _____

Receipt of Notice of Privacy Practices

I, _____, have received a copy of Rheumatology Associates' Notice of Privacy Practices.

_____
Patient Signature

Patient Request Regarding Health Information Release

(Friends/Family only – Not physicians)

Who to Contact

By completing and signing this document I hereby give permission to Rheumatology Associates to disclose as well as discuss any Protected Health Information related to my medical condition(s) with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- ☐ **I do not wish to give access to my Protected Health Information to anyone besides myself regarding my medical condition**

How to Contact
Note that you are responsible for any charges incurred in receiving our communications.

Alternate Form of Communication:

_____

_____
Patient Signature Date

RHEUMATOLOGY ASSOCIATES

Legal Representative

If the patient has a legal representative who will be signing these forms for them please fill out the information below.

Legal Representative Name	**Legal Representative Signature**
Legal Representative E-Mail	**Legal Representative Cellphone #**

RA RHEUMATOLOGY ASSOCIATES

Receipt of Cancellation Policy

I have received and understand the Rheumatology Associates policy and definitions regarding cancellations. _____ (*initials*)

Insurance Authorization

I hereby authorize any and all insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I understand that if my account should be turned over to a collection agency that I will be responsible for any fees incurred, up to and including 35% of the unpaid balance. I also authorize the physician to release any information required by my insurance company. _____ (*initials*)

Consent to Obtain External Prescription History

I authorize Rheumatology Associates and its providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit manager may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. _____ (*initials*)

General Authorization for Treatment

I authorize physicians, nurse practitioners and/or physician assistants of **Rheumatology Associates** who attend to me, their assistants, including those employed by **Rheumatology Associates** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ (*initials*)

Additional Treatment Opportunities

The doctors at Rheumatology Associates are involved in research that is designed to lead to better treatments for the types of medical problems experienced by the people who come to this clinic. As such, if they feel there is an opportunity that would be medically appropriate for you, you may be contacted by a qualified professional on their staff.

Patient Signature: _____ Date: _____

RHEUMATOLOGY ASSOCIATES

Main Phone: 214-540-0700; Main Fax: 214-540-0701

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Rheumatology Associates** to use and/or disclose certain protected health information (PHI) about me to Dr. _____ at _____.

Patient's Name_____ Date of Birth _____.

This authorization permits **Rheumatology Associates** to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:

_____
_____.

The information will be used or disclosed for the following purpose:
_____, or [ ] at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

The information may include information about HIV, AIDS, alcohol use, drugs, and mental health.

I do not have to sign this authorization in order to receive treatment from Rheumatology Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 8144 Walnut Hill Lane, Suite 800, Dallas, Texas 75231

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

RHEUMATOLOGY ASSOCIATES

8144 Walnut Hill Lane, Ste. 800
Dallas, TX 75231
Main Phone: 214-540-0700; Main Fax: 214-540-0701

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Dr._____**to disclose certain protected health information (PHI) about me to **Rheumatology Associates.**

Patient's Name_____ Date of Birth _____.

This authorization permits **Dr._____**to use and/or disclose the following individually identifiable health information (IIHI) and PHI about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.), or all records [if not specifically described, all records will be sent]:
_____
_____.

The information will be used or disclosed for the following purpose:
_____, or [ ] at the request of the individual.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this IIHI and PHI expires.

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Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

RHEUMATOLOGY ASSOCIATES

Patient History Form

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

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

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

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

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: _____

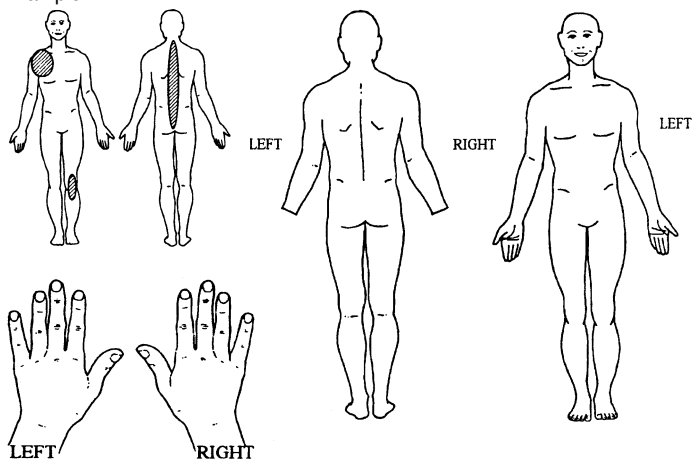
Date symptoms began (approximate): _____

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:

Diagnosis given:_____

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



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

RHEUMATIC DISEASE (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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
	Fibromyalgia			Chronic fatigue syndrome	
Other arthritis conditions:					

Patient's Name_____ Date_____ Physician Initials _____

REVIEW OF SYSTEMS

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

Musculoskeletal

❑ Morning stiffness
Lasting how long?
_____Minutes_____Hours
❑ Joint pain
❑ Joint swelling
List joints affected in the last 6 mos.
_____
_____
_____
_____
_____
❑ Muscle weakness
❑ Muscle tenderness

Constitutional

❑ Generalized weakness
❑ Fatigue
❑ Fever or chills
❑ Night sweats
❑ Recent weight loss
amount _____
❑ Recent weight gain
amount _____

Eyes

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

Dermatology

❑ Thickness
❑ Tightness
❑ Rash
❑ Unexpected hair loss
❑ Sun sensitive (sun allergy)
❑ Redness
❑ Hives
❑ Nodules/bumps
❑ Nail pits

Psychiatric

❑ Excessive worries
❑ Anxiety
❑ Panic attacks
❑ Easily losing temper
❑ Depression
❑ Agitation
❑ Difficulty falling asleep
❑ Difficulty staying asleep

Gastrointestinal

❑ Nausea
❑ Vomiting
❑ Abdominal pain
❑ Heartburn
❑ Diarrhea
❑ Mucus in stools
❑ Unusual constipation
❑ Blood in stools
❑ Black/tarry stools

Genitourinary

❑ Difficulty urinating
❑ Blood in urine
❑ Pain or burning on urination
❑ Pus in urine
❑ Cloudy urine
❑ Sexual difficulties
❑ Genital rash/ulcers

For Women Only:

❑ Vaginal dryness
❑ Vaginal discharge
Date of last period?_____/_____/_____/
Number of pregnancies? _____
Number of miscarriages? _____

For Men Only:

❑ Discharge from penis
❑ Prostate trouble

Respiratory

❑ Shortness of breath
❑ Cough
❑ Difficulty breathing at night
❑ Coughing of blood
❑ Wheezing (asthma)

Neurological System

❑ Numbness or tingling in hands
❑ Numbness or tingling in feet
❑ Headaches
❑ Dizziness
❑ Fainting
❑ Muscle spasm
❑ Cramping in legs at night
❑ Memory loss

Endocrine

❑ Excessive thirst

Hematologic/Lymphatic

❑ Blood clot in artery, vein, or lung
❑ Bleeding tendency
❑ Enlarged lymph nodes
❑ Anemia
❑ Transfusion/when _____

Allergic/Immunologic

❑ Frequent sneezing
❑ Increased susceptibility to infection

Ears–Nose–Mouth–Throat

❑ Dryness of mouth
❑ Sinus pain
❑ Difficulty swallowing
❑ Sores in mouth
❑ Ringing in ears
❑ Loss of hearing
❑ Nosebleeds
❑ Loss of smell
❑ Bleeding gums
❑ Loss of taste
❑ Frequent sore throats
❑ Hoarseness

Cardiovascular

❑ Chest pain
❑ Difficulty in breathing at night
❑ Cramping in calves when walking
❑ Swollen legs or feet
❑ Color changes of hands in the cold
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ Heart murmurs

Please state the date of your last:

Bone Densitometry_____/_____/_____ Mammogram_____/_____/_____ Eye exam_ / / Chest x–ray / /

Tuberculosis Test_____/_____/_____ Flu Vaccine_____/_____/_____ Pneumonia Vaccine_____/_____/_____

Tetanus Vaccine_____/_____/_____ Shingles Vaccine_____/_____/_____ Hepatitis B Vaccine_____/_____/_____

Patient's Name_____Date_____Physician Initials _____

YOUR PAST MEDICAL HISTORY: Have **YOU** ever been diagnosed with any of the following diseases?

❑ Cancer/Leukemia/Lymphoma	❑ Heart Disease	❑ Diabetes	❑ High blood pressure	❑ High Cholesterol	❑ Stroke
❑ Emphysema/COPD/Asthma	❑ Kidney disease	❑ Thyroid disease	❑ Jaundice/Hepatitis	❑ Tuberculosis	❑ Pneumonia
❑ HIV/ AIDS	❑ Headaches/Migraines	❑ Depression	❑ Nervous Breakdown	❑ Glaucoma	❑ Anemia
❑ Rheumatic Fever	❑ Epilepsy	❑ Psoriasis	❑ Colitis	❑ Iritis/Uveitis	❑ Sarcoidosis

Other significant illness (not listed above):_____

Previous Operations/ Surgical History

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**	
	Year of Birth	Health	Age at Death	Cause
Father				
Mother				

Number of sisters_____Number living_____Number deceased_____Number of brothers_____Number living_____Number deceased_____

Number of daughters_____Number living_____Number deceased_____Number of sons_____Number living_____Number deceased_____

Health of children: _____

Do you know of any close blood relative (parent, sibling or child) who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever_____	❑ Tuberculosis __
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy_____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism_____	❑ Psoriasis _____	

SOCIAL HISTORY:

Marital Status: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age_____ Major Illnesses_____

How many people in household?_____Relationship and age of each _____

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 _____

Do you drink caffeinated beverage? ❑ No ❑ Yes Cups/glasses per day?_____

Do you smoke? ❑No ❑Yes Amount per day_____ ❑ Previous smoker? How long ago?_____

Do you drink alcohol? ❑ No ❑ Yes Number per week_____Has anyone ever told you to cut down on your drinking? ❑ No ❑ Yes

Recreational drug use? ❑ No ❑ Yes If yes please list_____

Do you exercise regularly? ❑ **No** ❑ **Yes** Frequency_____Please describe _____

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** Over the Counter Medications as well, 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.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

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? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		❑	❑	❑	
Arthrotec (diclofenac + misoprostil)		❑	❑	❑	
Aspirin (including coated aspirin)		❑	❑	❑	
Celebrex (celecoxib)		❑	❑	❑	
Daypro (oxaprozin)		❑	❑	❑	
Dolobid (diflunisal)		❑	❑	❑	
Feldene (piroxicam)		❑	❑	❑	
Indocin (indomethacin)		❑	❑	❑	
Lodine (etodolac)		❑	❑	❑	
Mobic (meloxicam)		❑	❑	❑	
Motrin (ibupoprofen)		❑	❑	❑	
Naprosyn (naproxen)		❑	❑	❑	
Oruvail (ketoprofen)		❑	❑	❑	
Voltaren (diclofenac)		❑	❑	❑	
Other_____ _____		❑	❑	❑	
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Tylenol 3)		❑	❑	❑	
Hydrocodone (Vicodin, Lortab, Norco)		❑	❑	❑	
Ultram/Ultracet (tramadol)		❑	❑	❑	
Corticosteroids					
Decadron (dexamethasone)		❑	❑	❑	
Medrol dose pack (methylprednisolone)		❑	❑	❑	
Prednisone		❑	❑	❑	
Cortisone injection (where)_____ _____		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Arava (leflunomide)		❑	❑	❑	
Atabrine (quinacrine)		❑	❑	❑	
Azulfidine (sulfasalazine)		❑	❑	❑	
CellCept (mycophenolate mofetil)		❑	❑	❑	

Patient's Name_____ Date_____ Physician Initials _____

DMARDS - Continued					
Cytoxan (cyclophosphamide)		❑	❑	❑	
Imuran (azathioprine)		❑	❑	❑	
Methotrexate (rheumatrex)		❑	❑	❑	
Neoral or Sandimmune (Cyclosporine A)		❑	❑	❑	
Plaquenil (hydroxychloroquine)		❑	❑	❑	
Biologics					
Actemra (tocilizumab)		❑	❑	❑	
Cimzia (certolizumab)		❑	❑	❑	
Enbrel (etanercept)		❑	❑	❑	
Humira (adalimumab)		❑	❑	❑	
Kineret (anakinra)		❑	❑	❑	
Orencia (abatacept)		❑	❑	❑	
Remicade (Infliximab)		❑	❑	❑	
Rituxan (rituximab):		❑	❑	❑	
Simponi (golimumab)		❑	❑	❑	
Osteoporosis Medications					
Actonel (risedronate)		❑	❑	❑	
Boniva (ibandronate)		❑	❑	❑	
Estrogen (Premarin, etc.)		❑	❑	❑	
Evista (raloxifene)		❑	❑	❑	
Forteo (teriparatide)		❑	❑	❑	
Fosamax (alendronate)		❑	❑	❑	
Miacalcin nasal spray (calcitonin)		❑	❑	❑	
Prolia (denosumab)		❑	❑	❑	
Reclast (zoledronic acid)		❑	❑	❑	
Gout Medications					
Zyloprim (allopurinol)		❑	❑	❑	
Colcrys (colchicine)		❑	❑	❑	
Benemid (probenecid)		❑	❑	❑	
Uloric (febuxostat)		❑	❑	❑	
Krystexxa (pegloticase)					
Others					
Hyalgan/Synvisc/Orthovisc/Euflexxa injections		❑	❑	❑	
Cymbalta (dyloxetine)		❑	❑	❑	
Lyrica (pregabalin)		❑	❑	❑	
Neurontin (gabapentin)		❑	❑	❑	
Savella (milnacipran)		❑	❑	❑	
Muscle Relaxers		❑	❑	❑	
Sleep Medication		❑	❑	❑	
Other anti-depressants:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No If yes, list:

Patient's Name_____ Date_____ Physician Initials _____

ACTIVITIES OF DAILY LIVING

Who does most of the housework?_____Who does most of the shopping?_____Who does most of the yard work? _____

Because of health problems do you have difficulty: (Please check the appropriate response for each question.)	**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. Reaching behind your head?	___0	___1	___2	___3
10. Reaching behind your back?	___0	___1	___2	___3
11. Going to sleep?	___0	___1	___2	___3
12. Staying asleep due to pain?	___0	___1	___2	___3
13. Obtaining restful sleep?	___0	___1	___2	___3
14. Climbing stairs?	___0	___1	___2	___3
15. Descending stairs?	___0	___1	___2	___3
16. Working?	___0	___1	___2	___3
17. Getting along with family members?	___0	___1	___2	___3
18. Engaging in leisure time activities?	___0	___1	___2	___3

What is the hardest thing for you to do?_____

Do you use a cane, crutches, as walker or a wheelchair? (circle one)

Are you receiving disability?..... Yes ❑ No ❑ Are you applying for disability?.....Yes ❑ No ❑

Do you have a medically related lawsuit pending?.....Yes ❑ No ❑

Considering that all of the ways your arthritis has affected you over the past week, please place a vertical mark on the line below to show how you are feeling:

VERY GOOD 0 1 2 3 4 5 6 7 8 9 10 VERY POOR

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle on line below.

NO PROBLEM 0 1 2 3 4 5 6 7 8 9 10 MAJOR PROBLEM

How much pain have you had because of your condition OVER THE PAST WEEK? Please circle on the line below.

NONE 0 1 2 3 4 5 6 7 8 9 10 AS BAD AS IT COULD BE

Patient's Name_____Date_____Physician Initials _____