PHONE: 864-235-8396
FAX: 864-271-4092
WWW.PIEDMONTARTHRITIS.COM

Dear Patient,

Thank you for choosing Piedmont Arthritis Clinic. We have prepared this packet to help answer questions you may have and to inform you of our office operations.

WHEN YOU RECEIVE THIS PACKET, PLEASE IMMEDIATELY CALL TO CONFIRM YOUR APPOINTMENT AT (864) 527-2319.
THIS LETS US KNOW YOU GOT THE PACKET.

APPOINTMENT DATE: ___________
APPOINTMENT TIME: ___________

WE ASK THAT YOU ARRIVE AT LEAST 10 MINUTES EARLY WITH YOUR PAPERWORK COMPLETED. IF YOU ARE LATE, OR YOUR PAPERWORK IS NOT COMPLETE, **YOUR APPOINTMENT MAY BE RESCHEDULED**.

OFFICE HOURS - Our office is open 7:30 to 5:00.

TELEPHONE SYSTEM – Our phone hours are 8:30 to 12:00 and 1:00 to 4:30. We make every attempt to answer calls, however we have a very high call volume. If you are transferred to voicemail, please leave all pertinent information and we will take care of your issue as quickly as possible. Please allow 24 hours before calling again.

PRESCRIPTION REFILL REQUESTS – Medication refills are not considered urgent requests. If you need a refill on your prescription, please call during regular phone hours. Refill requests can take 24-48 hours.

BILLING AND INSURANCE - Our physicians participate with most insurance plans. In the event that we do not participate with your insurance plan, you will be expected to pay for your visit in full. Co-pays, deductible amounts, and co-insurance are expected to be paid at the time of service. If there is a balance after your insurance pays, payment is due immediately upon receipt of your bill. Self-pay patients are expected to pay for their visit before seeing the physician.

CONFIDENTIALITY OF YOUR MEDICAL RECORDS AND PERSONAL INFORMATION – Information that we receive on any patient is strictly confidential. Notification of our HIPAA privacy rules are available in the office and on our website at www.piedmontarthritis.com.

NO SHOWS AND CANCELLATIONS – We request that you give at least 24 hours' notice if you need to cancel or reschedule your appointment. Failure to do so could result in a "no show" charge and/or discharge from our practice.

TRANSLATOR SERVICES – Please call if you need translation services. Por favor llame si el traductor es necesario.

3 ST FRANCIS DRIVE, SUITE 400 GREENVILLE, SOUTH CAROLINA 29601

PHONE: 864-235-8396
FAX: 864-271-4092
WWW.PIEDMONTARTHRITIS.COM

OUR ADDRESS IS 3 ST FRANCIS DRIVE, SUITE 400 IN GREENVILLE, SC 29601.

We are located in the St Francis Hospital Outpatient Medical Office facing Academy/HWY 123. It is a 4-story brick building with a large overhang at the entrance and you are welcome to use the FREE valet parking provided. We are located on the fourth floor, Suite 400.

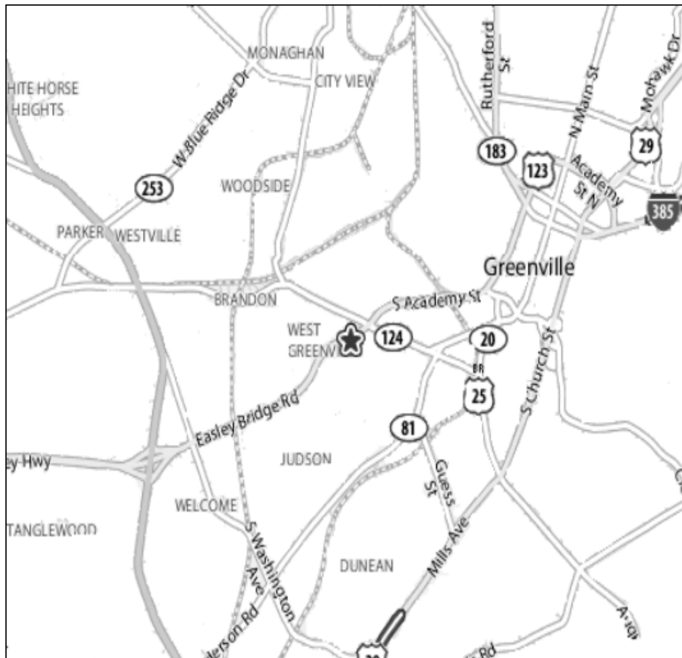
DRIVING DIRECTIONS:

FROM 385 (Headed North) - Turn right on Academy/HWY 123 (just before the Bon Secours Wellness Arena) and proceed 2.5 miles down Academy. After passing Pendleton Road, turn left onto St. Francis Drive, then right into our parking lot.

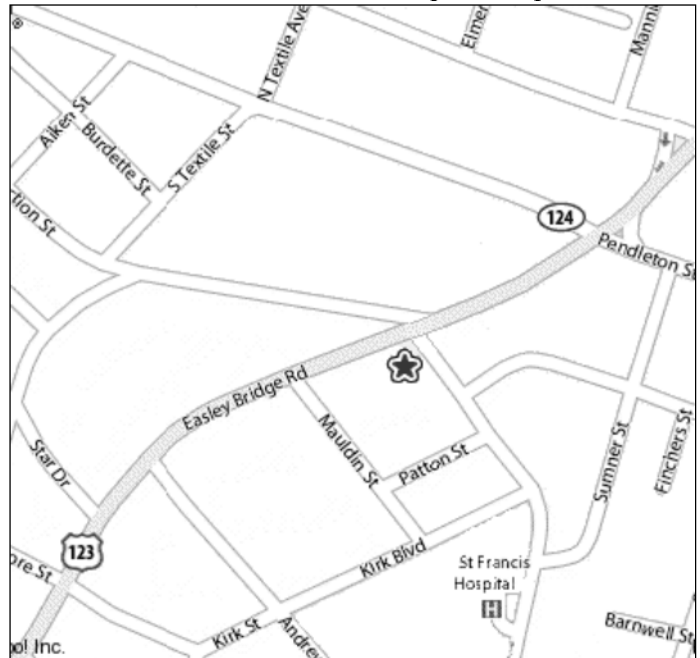
FROM ANDERSON – Take 85 North. Merge onto US-29/US 185 via Exit 42 towards Greenville. Turn Left at Augusta (there is a Taco Bell on the corner). Turn left on Dunbar (first light). Turn right onto St. Francis Drive. Drive under the bridge, past the emergency room and a house on the left. Turn left into the large parking lot at the back of the hospital.

FROM CLEMSON/SENECA/EASLEY – Take Hwy 123 into Greenville. Turn right onto St. Francis Drive and then right into our parking lot.

GREENVILLE,
South Carolina



3 ST FRANCIS DRIVE, SUITE 400
Located in the St. Francis Hospital Outpatient Center



This map was provided by Yahoo.com. For specific directions please contact our office at 864-235-8396 or log on to maps.yahoo.com for driving directions from your location.

PATIENT DEMOGRAPHICS

DATE: ____________

Prefix: ❑ Dr ❑ Mr ❑ Miss ❑ Mrs ❑ Ms

Last Name: ______________________

First Name: ______________________ MI: ___

Address: ______________________

____

City: ______________________

State: __________ Zip: __________

Home Phone #: ______________________

Cell Phone #: ______________________

Work Phone #: ______________ x ______

Family Physician: ______________________

Phone #: ______________________

Referring Physician: ______________________

Phone #: ______________________

Date of Birth: ______________________

Gender: ❑ Male ❑ Female

Marital Status: ______________________

SS# ______________________

Employer: ______________________

❑Homemaker ❑Disabled ❑Not Employed ❑Retired

❑Full Time ❑Part Time ❑Self Employed

Student? ❑No ❑Full Time ❑Part Time

Personal Email: ______________________

Race: ❑Black/African American ❑White ❑Hispanic ❑Other: ______________

Ethnicity: ❑Non-Hispanic ❑Hispanic

Primary Language: ❑English ❑Other:______________ (Please call if you need a translator)

Spouse: ______________________ Phone #: ______________

Other Contact: ______________________ Relationship: ______________ Phone #: ______________

PRESCRIPTION INSURANCE COVERAGE – PLEASE PROVIDE US WITH A COPY OF YOUR CARD(S)

Insurance Name: ______________________ RxBIN: ______________________

ID#: ______________________ RxGRP: ______________________

Local Pharmacy Name: ______________________ Phone #: ______________

Address or Cross-Streets: ______________________

Mail Order Pharmacy Name: ______________________ Phone #: ______________

Other CURRENT Physicians (Please use back if necessary):

Physician Name: ______________________

Type (Cardiologist/Pulmonologist/etc): ______________

Physician Name: ______________________

Type (Cardiologist/Pulmonologist/etc): ______________

Physician Name: ______________________

Type (Cardiologist/Pulmonologist/etc): ______________

Physician Name: ______________________

Type (Cardiologist/Pulmonologist/etc): ______________

INSURANCE INFORMATION – PLEASE PROVIDE US WITH A COPY OF YOUR CARD(S)

Primary Insurance Name: ______________________

ID#: ______________________

Co-pay $______ Deductible $__________ then ______%

Policy Holder Name: ______________________

SS# (policy holder): ______________________

Employer (policy holder): ______________________

Date of Birth (policy holder): ______________________

Secondary Insurance Name: ______________________

ID#: ______________________

Co-pay $______ Deductible $__________ then ______%

Policy Holder Name: ______________________

SS# (policy holder): ______________________

Employer (policy holder): ______________________

Date of Birth: ______________________

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for charges incurred by myself or any dependent if my insurance company denies payment for any reason. I understand that any financial responsibility on my part will be paid in full upon receiving a bill (unless financial arrangements have been made). I hereby assign all benefits to be paid directly to my rendering physician. This assignment includes any treatment within a hospital/facility setting. I hereby authorize Piedmont Arthritis Clinic to provide any identifiable health information to my insurance carrier for the necessity of processing insurance claims.

SIGNATURE: **DATE:**

HIPAA AUTHORIZATION

MRN: ___________ **DATE:** ____________

NAME: ___________________________________ DATE OF BIRTH: ___________________________

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Piedmont Arthritis Clinic's Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Signature: ____________________________________ **Date:** ___________________________________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Which number is best number to contact you…

❑ Home ❑ Cell ❑ Work

May we leave Automated Messages…

for appointment reminders? ❑yes ❑no
for "Normal" result messages? ❑yes ❑no
for Health Maintenance messages? ❑yes ❑no
for RX Refill notifications? ❑yes ❑no
for General Notifications? ❑yes ❑no

Prescription History

May we obtain your prescription history from your pharmacy/RX Hub? ❑yes ❑no

Message Type

If we reach a voice mail or anyone other than you when calling, what type of message may we leave?

Home Phone ❑None ❑Brief ❑Detailed
Cell Phone ❑None ❑Brief ❑Detailed
Work Phone ❑None ❑Brief ❑Detailed

EXAMPLES

brief: *"Please call regarding your lab results"; "your prescription has been called into your pharmacy"*

detailed: *"Your CBC was 24"; "Prednisone 2.5 called to Walgreens"*

Clinical Trials

If you qualify, may we contact you regarding participation in clinical trials? ❑yes ❑no

Authorized Persons/Places

I, hereby authorize the use and detailed disclosure of my protected health information under the federal health privacy law (HIPAA) to the following persons/places:

Name: ______________________________________
Relationship: _________________________________
Phone # _____________________________________

Name: ______________________________________
Relationship: _________________________________
Phone # _____________________________________

Name: ______________________________________
Relationship: _________________________________
Phone # _____________________________________

Name: ______________________________________
Relationship: _________________________________
Phone # _____________________________________

Expiration Date of Authorization

This authorization is effective 3 years or

❑ through _____/_____/__________

❑ until revoked by patient or patient's representative

I understand that Piedmont Arthritis Clinic will disclose health information to my insurance company upon their request for payment or to authorize treatment. They will also send the necessary medical information to facilitate my care upon referral to another physician or for testing. For further information, I will refer to their Notice of Privacy Practices or request to speak to their Privacy Official. I also understand that if the above person or entities receiving this information are not a covered by federal privacy regulations, the released information might be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke or change this authorization at any time by notifying Piedmont Arthritis Clinic in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Piedmont Arthritis Clinic before receiving my revocation.

SIGNATURE: ____ **DATE:** ______________________

CLINICAL HISTORY FORM

TODAY'S DATE: ____________________

NAME: ____________________ **DATE OF BIRTH:** ____________ **AGE:** ________

TODAY'S DATE: ____________________

WHO REFERRED YOU HERE?

NAME OF YOUR PRIMARY CARE PHYSICIAN:

DESCRIBE BRIEFLY YOUR PRESENT SYMPTOM(S):

WHEN DID YOUR SYMPTOMS START?

LIST JOINTS AFFECTED IN THE LAST 6 MONTHS:

PAIN	SWELL	WHERE?
☐	☐	"ALL OVER"
☐	☐	ALL JOINTS
☐	☐	MANY JOINTS
☐	☐	ALL MUSCLES
☐	☐	MANY MUSCLES
☐	☐	JAWS
☐	☐	CHEST
☐	☐	NECK
☐	☐	MID BACK
☐	☐	LOWER BACK
☐	☐	LT RT SHOULDERS
☐	☐	LT RT ELBOWS
☐	☐	LT RT WRISTS
☐	☐	LT RT HANDS
☐	☐	LT RT FINGERS
☐	☐	LT RT HIPS
☐	☐	LT RT KNEES
☐	☐	LT RT ANKLES
☐	☐	LT RT FEET
☐	☐	LT RT TOES

DO YOU HAVE:

- Joint Pain
- Joint Swelling
- Decreased Mobility
- Fatigue
- Fever
- Muscle Weakness
- Muscle tenderness
- Rashes
- Stiffness
- Morning Stiffness?
  - Lasts how long?
  - _______ Minutes

HOW SEVERE IS IT?

- Mild
- Mild to Moderate
- Moderate to Severe
- Severe
- Changes in Intensity

WHAT BEST DESCRIBES IT?

- Gradual
- Intermittent
- Sudden
- Frequent
- Constant
- Comes and goes

WHEN IS IT WORST?

- Morning
- Afternoon
- Evening
- Night

HOW DOES IT FEEL?

- Achy
- Soreness
- Burning
- Dull
- Sharp
- Shooting
- Throbbing
- Tingly
- Numb
- Hot

WHAT MAKES IT WORSE?

- Bending
- Reaching
- Lifting
- Sitting
- Standing
- Walking
- Over exertion
- Standing up
- Stress
- Premenstrual period
- Cold weather
- Wet Weather

WHAT MAKES IT BETTER?

- Heat
- Ice
- Lying down
- Medication
- Rest
- Sitting
- Standing
- Stretching
- Shower/bath
- Activity
- Massage

WHAT DIAGNOSIS HAVE YOU BEEN GIVEN, IF ANY?

PLEASE LIST THE PRACTITIONERS AND SPECIALTIES YOU HAVE SEEN FOR THIS:

PREVIOUS TREATMENT FOR THIS PROBLEM (INCLUDE PHYSICAL THERAPY, SURGERY, ALTERNATIVE TREATMENTS AND INJECTIONS):

CURRENT MEDICATION

TODAY'S DATE: ____________________

NAME: ____________________ DATE OF BIRTH: ____________________

CURRENT PRESCRIPTION MEDICATIONS (COMPLETE OR ATTACH LIST)

MEDICATION NAME	STRENGTH	QUANTITY TAKEN	TIMES PER DAY
(EXAMPLE) PREDNISONE	5 MG	2 TABLETS	3 TIMES PER DAY

OVER THE COUNTER MEDICATIONS/NUTRITIONAL SUPPLEMENTS/VITAMINS

MEDICATION NAME	STRENGTH	QUANTITY TAKEN	TIMES PER DAY

ALLERGIES/ADVERSE REACTIONS

MEDICATION	REACTION	MEDICATION	REACTION

MEDICATION HISTORY

TODAY'S DATE: ________________________________

NAME: ____ **DATE OF BIRTH:** ________________________________

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.

	LENGTH OF TIME	HELPED A LOT	HELPED SOME	NO HELP AT ALL	REACTIONS
NON-STEROIDAL ANTI-INFLAMMAORY DRUGS (NSAIDS)		❑	❑	❑	
CIRCLE ANY YOU HAVE TAKEN IN THE PAST: ACTRON, ADVIL, AFLAXEN, ALEVE, AMIGESIC, ANAFLEX, ANSAID, ARGESIC-SA, ARTHROTEC, ASPIRIN, CAMBIA, CATAFLAM, CELEBREX, CELOCIXIB, CHOLINE-MAGNESIUM-TRISALICYLATE, CLINORIL, DAYPRO, DICLOFENAC, DIFLUNISAL DISALCID, DOLOBID, DYLOJECT, ETODOLAC, FELDENE, FENOPROFEN, FLANAX, FROTEK, GENPRIL, IBUPROFEN, INDOCIN, INDOMETHACIN, KETOPROFEN, LODINE, MARTHRITIC, MECLOMEN, MECLOFENAMATE, MIDOL, MONO-GESIC, MOTRIN, NALFON, NAPROLAN, NAPROXEN, ORUVAIL, ORUDIS, OXAPROZIN, PIROXICAM, PROPRINAL, SALFLEX, SALSITAB, SULINDAC, TIVORBEX, TOLMETIN, TOLECTIN, TRICOSAL, TRILISATE, VOLTAREN, ZIPSOR, ZORVOLEX					
PAIN RELIEVERS	**LENGTH OF TIME**	**HELPED A LOT**	**HELPED SOME**	**NO HELP AT ALL**	**REACTIONS**
ACETAMINOPHEN PRODUCTS LIKE TYLENOL		❑	❑	❑	
CODEINE PRODUCTS LIKE ENDOCET, HYDROCODONE, LORTAB, MS CONTIN, NORCO, OXYCODONE, OXYCONTIN, PERCOCET, ROXICET, VICODIN		❑	❑	❑	
PROPOXYPHENE PRODUCTS LIKE DARVON		❑	❑	❑	
MORPHINE PRODUCTS LIKE ARYMO, KADIAN, VINZA		❑	❑	❑	
TRAMADOL PRODUCTS LIKE CONZIP, ULTRACET, ULTRAM		❑	❑	❑	
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDS)	**LENGTH OF TIME**	**HELPED A LOT**	**HELPED SOME**	**NO HELP AT ALL**	**REACTIONS**
ACTEMRA		❑	❑	❑	
ARAVA		❑	❑	❑	
AZATHIOPRINE/IMURAN		❑	❑	❑	
CIMZIA		❑	❑	❑	
CORTISONE/PREDNISONE		❑	❑	❑	
CYCLOPHOSPHAMIDE/CYTOXAN		❑	❑	❑	
CYCLOSPORINE		❑	❑	❑	
ENBREL		❑	❑	❑	
HUMIRA		❑	❑	❑	
HYDROXYCHLOROQUINE/PLAQUENIL		❑	❑	❑	
KINERET		❑	❑	❑	
METHOTREXATE		❑	❑	❑	
MINOCYCLIN/MINOCIN		❑	❑	❑	
ORENCIA		❑	❑	❑	
PENICILLAMINE/CUPRIMINE		❑	❑	❑	
QUINACRINE		❑	❑	❑	
REMICADE/INFLECTRA/RENFLEXIS		❑	❑	❑	
RITUXAN		❑	❑	❑	
SIMPONI/SIMPONI ARIA		❑	❑	❑	
SULFASALAZINE/AZULFIDINE		❑	❑	❑	
XELJANZ		❑	❑	❑	
OSTEOPOROSIS MEDICATIONS	**LENGTH OF TIME**	**HELPED A LOT**	**HELPED SOME**	**NO HELP AT ALL**	**REACTIONS**
ESTROGEN		❑	❑	❑	
FOSAMAX/BINOSTO/ALENDRONATE		❑	❑	❑	
DIDRONEL/ETIDRONATE		❑	❑	❑	
EVISTA/RALOXIFENE		❑	❑	❑	
MIACALCIN/CALCITONIN NASAL		❑	❑	❑	
ACTONEL/ATELVIA		❑	❑	❑	
PROLIA		❑	❑	❑	
RECLAST/ZOLEDRONIC ACID		❑	❑	❑	
GOUT MEDICATIONS	**LENGTH OF TIME**	**HELPED A LOT**	**HELPED SOME**	**NO HELP AT ALL**	**REACTIONS**
ALLOPURINOL		❑	❑	❑	
BENEMID/PROBENECID		❑	❑	❑	
COLCICINE		❑	❑	❑	
KRYSTEXXA		❑	❑	❑	
ULORIC		❑	❑	❑	
ZURAMPIC		❑	❑	❑	

RHEUMATOLOGIC HISTORY

TODAY'S DATE: ______________________

NAME: ______________________ DATE OF BIRTH: ______________________

☑ if YOU have had any of the following..... List any BLOOD relatives with these issues

- ❑ Ankylosing Spondylitis .... ❑ ______
- ❑ Arthritis (Type Unknown)......................... ❑ ______
- ❑ Bechet's Syndrome................................... ❑ ______
- ❑ Childhood Arthritis................................... ❑ ______
- ❑ Arthritis (Type Unknown)......................... ❑ ______
- ❑ Bechet's Syndrome................................... ❑ ______
- ❑ Childhood Arthritis................................... ❑ ______
- ❑ Degenerative Disc Disease .... ❑ ______
- ❑ Cervical Disc Disease............................... ❑ ______
- ❑ Lumbar Disc Disease................................ ❑ ______
- ❑ Dermatomyositis .... ❑ ______
- ❑ Fibromyalgia .... ❑ ______
- ❑ Gout... ❑ ______
- ❑ Herniated Disc.. ❑ ______
- ❑ Lupus or "SLE"... ❑ ______
- ❑ Plantar Fasciitis .... ❑ ______
- ❑ Polymyalgia Rheumatica.......................... ❑ ______
- ❑ Polymyositis .... ❑ ______
- ❑ Psoriasis/Psoriatic Arthritis .... ❑ ______
- ❑ Rheumatoid Arthritis................................ ❑ ______
- ❑ Sciatica .... ❑ ______
- ❑ Scleroderma.. ❑ ______
- ❑ Sjogren's Syndrome .... ❑ ______
- ❑ Temporal Arteritis .... ❑ ______
- ❑ Vasculitis.. ❑ ______
- ❑ Osteoporosis .... ❑ ______
- ❑ Hip Fracture.. ❑ ______
- ❑ Osteoarthritis .... ❑ ______
  - ❑ ANKLE/FOOT OSTEOARTHRITIS
  - ❑ HAND OSTEOARTHRITIS
  - ❑ HIP OSTEOARTHRITIS
  - ❑ KNEE OSTEOARTHRITIS
  - ❑ LUMBAR OSTEOARTHRITIS
  - ❑ NECK OSTEOARTHRITIS
  - ❑ SHOULDER OSTEOARTHRITIS
  - ❑ THORACIC OSTEOARTHRITIS
- ❑ BUNIONS
- ❑ CARPAL TUNNEL
- ❑ COSTOCHONDRITIS
- ❑ FREQUENT FALLS
- ❑ GETTING SHORTER
- ❑ LOW BACK PAIN
- ❑ LOW CALCIUM INTAKE
- ❑ LOW VITAMIN D
- ❑ NEUROMAS
- ❑ OSTEOPENIA
- ❑ PAST STEROID INTAKE
- ❑ RAYNAUD'S
- ❑ ROTATOR CUFF DISEASE
- ❑ SCOLIOSIS
- ❑ TMJ
- ❑ OTHER FRACTURES – PLEASE DESCRIBE:

FAMILY HISTORY				
BIOLOGIC PARENTS	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
FATHER				
MOTHER				
# of Brothers			# of Sisters	
Number of Siblings Deceased				
# of Sons			# of Daughters	
Number of Children Deceased				
Health of Children				

RISK SCREENING - Mark with ❑ If Applicable

FAMILY HISTORY OF:

- ❑ Alcohol Abuse
- ❑ Illegal Drugs Use
- ❑ RX Drug Abuse

PERSONAL HISTORY OF:

- ❑ Alcohol Abuse
- ❑ Illegal Drugs Use
- ❑ RX Drug Abuse
- ❑ Preadolescent sexual abuse
- ❑ ADD, OCD, Bipolar, Schizophrenia
- ❑ Depression

OTHER MEDICAL HISTORY

TODAY'S DATE: ___________________________________

NAME: ____ **DATE OF BIRTH:** ________________________________

CARDIOLOGY:
- ❑ Atrial Fibrillation
- ❑ CHF
- ❑ Heart Attacks
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ HTN
- ❑ Pericarditis
- ❑ Peripheral Vascular Disease

RESPIRATORY:
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Emphysema
- ❑ Interstitial Lung Disease
- ❑ Pneumonia
- ❑ Sinus/Allergies
- ❑ Sleep Apnea
- ❑ TB

DERMATOLOGY:
- ❑ Chronic Hives
- ❑ Eczema
- ❑ Hair loss
- ❑ Psoriasis

OPHTHALMOLOGY:
- ❑ Blindness
- ❑ Cataracts
- ❑ Diabetic retinopathy
- ❑ Glaucoma
- ❑ Iritis
- ❑ Retinal Detachment
- ❑ Retinal Hemorrhage
- ❑ Scleritis

GASTROINTESTINAL:
- ❑ Barrett's Esophagus
- ❑ Celiac Disease
- ❑ Cirrhosis
- ❑ Colon Polyps
- ❑ Crohn's Colitis
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ Esophageal Stricture
- ❑ GERD
- ❑ GI bleeding
- ❑ Irritable Bowel
- ❑ Ulcerative Colitis
- ❑ Ulcers

KIDNEY:
- ❑ Diabetic Kidney Disease
- ❑ Kidney Failure
- ❑ Kidney Stone
- ❑ Renal Cyst
- ❑ Renal Insufficiency

OB/GYN & GENITOURINARY:
- ❑ Chronic UTI
- ❑ Infertility
- ❑ Menopause
- ❑ Polycystic Ovarian Disease
- ❑ Prostate Disease

# of Pregnancies:______________

# of Miscarriages:_____________

NEUROLOGICAL:
- ❑ Bell's Palsy
- ❑ Guilliame Barre
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Parkinson's
- ❑ Peripheral Neuropathy
- ❑ Polio
- ❑ Seizures
- ❑ Stroke

ENDOCRINE:
- ❑ Diabetes
- ❑ High Calcium
- ❑ Overactive Thyroid
- ❑ Thyroid Disease
- ❑ Underactive Thyroid

INFECTIOUS DISEASES:
- ❑ Abscesses
- ❑ Bacterial Endocarditis
- ❑ Cellulitis
- ❑ Hepatitis: ○A ○B ○C
- ❑ HIV/Aids
- ❑ Malaria
- ❑ Osteomyelitis
- ❑ Shingles
- ❑ Tuberculosis

PSYCHOLOGICAL:
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ OCD Disorder
- ❑ Panic Attacks
- ❑ Personality Disorder
- ❑ Post-Traumatic Stress
- ❑ Schizophrenia

HEMATOLOGY/ONCOLOGY:
- ❑ Anemia – Iron deficient
- ❑ Anemia – B12 deficiency
- ❑ Anemia - All Others
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ Kidney Cancer
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Ovarian Cancer
- ❑ Pancreatic Cancer
- ❑ Prostate Cancer
- ❑ Skin Melanoma

OTHER PERTINENT MEDICAL HISTORY: ____

OTHER MEDICAL HISTORY

TODAY'S DATE: ______________________

NAME: ______________________

DATE OF BIRTH: ______________________

SURGERIES — DATE?

- ❑ Cataracts ______
- ❑ Thyroid ______
- ❑ Tonsils ______
- ❑ Carpal Tunnel ______
- ❑ Skin Cancers ______
- ❑ Appendix ______
- ❑ Prostate ______
- ❑ Bladder Repair ______
- ❑ Gallbladder ______
- ❑ Bunionectomy ______
- ❑ Cervical Disk ______
- ❑ Lumbar Disk ______
- ❑ Gastrectomy ______
- ❑ diverticulitis/colon ______
- ❑ Hemorrhoids ______
- ❑ Gastric Bypass ______
- ❑ Hiatal Hernia ______
- ❑ Heart ______
- ❑ Pacemaker ______
- ❑ Heart Bypass ______
- ❑ Stents ______
- ❑ Valve Replacement ______
- ❑ Arthroscopic Knee: ○ L______ ○ R______
- ❑ Total Hysterectomy ______
- ❑ Partial Hysterectomy ______
  - **# of Ovaries removed:** ○ 1 ○ 2
- ❑ hip replacement: ○ L______ ○ R______
- ❑ Shoulder replacement: ○ L______ ○ R______
- ❑ Knee replacement: ○ L______ ○ R______

Other: ______

IMMUNIZATIONS/VACCINATIONS

Pneumonia	Date Received: ______
Influenza	Date Received: ______
Hepatitis B	Date Received: ______
Shingles	Date Received: ______
Other	Date Received: ______

SOCIAL HISTORY

RELATIONSHIP STATUS:

- ❑ Never Married ❑ Married
- ❑ Divorced ❑ Separated
- ❑ Widowed ❑ Partner

EDUCATION: CIRCLE HIGHEST LEVEL

- ❑ Grade School 7 8 9 10 11 12 ❑ GED
- ❑ College 1 2 3 4
- ❑ Graduate School ______

OCCUPATION: ______

Average work hours per week: ______

Employer: ______

If you are not working, are you (a):

- ❑ Homemaker ❑ Retired
- ❑ On sick leave; Date last worked? ______
- ❑ Disabled; As of what date? ______
  - Receiving disability or SSI? ❑ No ❑ Yes
  - What is your disability? ______

DO YOU SMOKE?

- ❑ No
- ❑ Former – how long ago? ______
- ❑ Yes; Packs per Day? 1/2pk 1 pack 2 packs

DO YOU DRINK ALCOHOL?

- ❑ No
- ❑ Yes – What do you drink: ______
  - How Much per week: ______
  - Has anyone ever told you to cut down on your drinking? ❑ No ❑ Yes

DO YOU USE DRUGS FOR NON-MEDICAL REASONS?

- ❑ NO
- ❑ Yes – Please list:

ARE YOU CURRENTLY, OR HAVE YOU PREVIOUSLY SEEN A PAIN MANAGEMENT PHYSICIAN?

- ❑ No
- ❑ Yes - who? ______

SYSTEM REVIEW

TODAY'S DATE: ______________________

NAME: ______________________ **DATE OF BIRTH:** ______________________

AS YOU REVIEW THE FOLLOWING LIST, PLEASE CHECK ANY PROBLEMS WHICH HAVE SIGNIFICANTLY AFFECTED YOU IN THE LAST 6 MONTHS.

GENERAL:

RATE YOUR DAYTIME ENERGY: ______________________

0=FULL ENERGY 10=EXHAUSTED

- ❑ CHILLS
- ❑ FATIGUE
- ❑ FEVER
- ❑ NIGHT SWEATS
- ❑ RECENT WEIGHT GAIN – # ________
- ❑ RECENT WEIGHT LOSS – # ________
- ❑ WEAKNESS

OPHTHALMOLOGY:

- ❑ DOUBLE OR BLURRED VISION
- ❑ DRY EYES
- ❑ EYE PAIN
- ❑ ITCHY EYES
- ❑ RED EYES
- ❑ VISION LOSS

ENT:

- ❑ HEARING LOSS
- ❑ RINGING IN EARS
- ❑ STUFFY NOSE
- ❑ DRY MOUTH
- ❑ MOUTH SORES
- ❑ TROUBLE CHEWING
- ❑ TASTE/SMELL LOSS

RESPIRATORY:

- ❑ SHORTNESS OF BREATH
- ❑ SWOLLEN LEGS OR FEET
- ❑ WHEEZING
- ❑ COUGH

CARDIOLOGY:

- ❑ CHEST PAIN
- ❑ DIZZINESS
- ❑ IRREGULAR HEARTBEAT
- ❑ PALPITATIONS
- ❑ SWOLLEN LEGS/FEET

GASTROENTEROLOGY:

- ❑ BLOOD IN STOOL
- ❑ CHANGE IN BOWEL
- ❑ HEARTBURN
- ❑ INCREASED CONSTIPATION
- ❑ NAUSEA
- ❑ PERSISTENT DIARRHEA
- ❑ VOMITING

HEMATOLOGY/LYMPH:

- ❑ EASY BLEEDING
- ❑ SWOLLEN GLANDS
- ❑ TENDER GLANDS

DERMATOLOGY:

- ❑ HAIR LOSS
- ❑ OPEN WOUNDS OR SORES
- ❑ RASH

INTEGUMENTARY:

- ❑ BLUE OR WHITE FINGERS
- ❑ EASY BRUISING
- ❑ HIVES
- ❑ NODULES/BUMPS
- ❑ REDNESS
- ❑ SUN SENSITIVITY
- ❑ TIGHTNESS

GENITOURINARY:

- ❑ BLOOD IN URINE
- ❑ FREQUENT URINATION
- ❑ INCONTINENCE
- ❑ INTIMACY ISSUES
- ❑ PAINFUL GENITAL ULCER
- ❑ RECURRENT UTI

FOR WOMEN ONLY:

- ❑ AGE WHEN PERIODS BEGAN:

HAVE YOU REACHED MENOPAUSE?

- ❑ NO
- ❑ YES – WHAT AGE?

NEUROLOGY:

RATE MEMORY: ______________

0=EXCELLENT,10=POOR

- ❑ DIZZINESS
- ❑ FAINTING
- ❑ FREQUENT FALLS
- ❑ LOSS OF BALANCE
- ❑ LOSS OF CONSCIOUSNESS
- ❑ MEMORY LOSS
- ❑ MUSCLE SPASM
- ❑ NIGHT SWEATS
- ❑ TINGLING/NUMBNESS

PSYCHOLOGY:

RATE YOUR:

SLEEP: ______________

0=EXCELLENT, 10=POOR

MORNING RESTED-NESS: ________

0=RESTED, 10=EXHAUSTED

EMOTIONAL STRESS: __________

0=NONE, 10=SEVERE

- ❑ ANXIETY
- ❑ DEPRESSION
- ❑ TROUBLE SLEEPING
  - ❑ HARD TO GET TO SLEEP
  - ❑ HARD TO STAY ASLEEP

DO YOU NAP? ❑ YES ❑ NO

WHAT WAKES YOU FROM SLEEP?

- ❑ SPOUSE
- ❑ CHILDREN
- ❑ SNORING
- ❑ BURNING FEET
- ❑ PAIN
- ❑ HEADACHES
- ❑ HEARTBURN
- ❑ NUMB HANDS
- ❑ FULL BLADDER
- ❑ CHOKING
- ❑ STIFFNESS

DIAGNOSTIC TESTING

HAVE YOU HAD ANY:	WHEN?	WHERE?
❑ MRI		
❑ CT Scan		
❑ Bone Density		
❑ Eye Exam		
❑ TB Testing		Result: Pos/Neg

ADDITIONAL INFORMATION

WHICH HAND IS DOMINANT? ❑ Right ❑ Left

HARDWARE /METAL IN BODY:

- ❑ Aneurysm clips
- ❑ Aortic clips
- ❑ Cochlear implants
- ❑ Hearing aid
- ❑ Neurotransmitter
- ❑ Prosthesis
- ❑ Insulin pump
- ❑ Shrapnel
- ❑ Metal slivers in eyes
- ❑ Fractured bones w/rods, plates, screws, nails or clips

STATUS/GOALS

NAME: ______________________ **TODAY'S DATE:** ______________________

DATE OF BIRTH: ______________________

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.

MARK THE <u>ONE</u> BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

1. **OVER THE PAST WEEK**, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of bed?	❑ 0	❑ 1	❑ 2	❑ 3
Lift a full cup or glass to your mouth?	❑ 0	❑ 1	❑ 2	❑ 3
Walk outdoors on flat ground?	❑ 0	❑ 1	❑ 2	❑ 3
Wash and dry your entire body?	❑ 0	❑ 1	❑ 2	❑ 3
Bend down to pick up clothing from the floor?	❑ 0	❑ 1	❑ 2	❑ 3
Turn regular faucets on and off?	❑ 0	❑ 1	❑ 2	❑ 3
Get in and out of a car, bus, train, or airplane?	❑ 0	❑ 1	❑ 2	❑ 3
Walk two miles?	❑ 0	❑ 1	❑ 2	❑ 3
Participate in recreational activities/sports as you would like?	❑ 0	❑ 1	❑ 2	❑ 3

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION <u>OVER THE PAST WEEK</u>?
PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

○ **0** ○ **0.5** ○ **1** ○ **1.5** ○ **2** ○ **2.5** ○ **3** ○ **3.5** ○ **4** ○ **4.5** ○ **5** ○ **5.5** ○ **6** ○ **6.5** ○ **7** ○ **7.5** ○ **8** ○ **8.5** ○ **9** ○ **9.5** ○ **10**

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

○ **0** ○ **0.5** ○ **1** ○ **1.5** ○ **2** ○ **2.5** ○ **3** ○ **3.5** ○ **4** ○ **4.5** ○ **5** ○ **5.5** ○ **6** ○ **6.5** ○ **7** ○ **7.5** ○ **8** ○ **8.5** ○ **9** ○ **9.5** ○ **10**

GOALS – LET'S WORK TOGETHER TO REACH YOUR GOALS!

REGARDING YOUR HEALTH, WHAT WOULD YOU LIKE TO IMPROVE? WHY?

WHAT COULD INTERFERE WITH PLANS?

HOW IMPORTANT IS THIS TO ME?

NOT AT ALL IMPORTANT — MOST IMPORTANT

○ **0** ○ **0.5** ○ **1** ○ **1.5** ○ **2** ○ **2.5** ○ **3** ○ **3.5** ○ **4** ○ **4.5** ○ **5** ○ **5.5** ○ **6** ○ **6.5** ○ **7** ○ **7.5** ○ **8** ○ **8.5** ○ **9** ○ **9.5** ○ **10**

TOGETHER, YOU AND YOUR RHEUMATOLOGIST WILL DETERMINE: What steps should you take, what tools can help you succeed, how you will know if your plan is working and when you should see results.

For Office Use Only

1	0.3	6	2	11	3.7	16	5.3	21	7	26	8.7	1. FN (0-10)	2. PN (0-10)	3. PTGL (0-10)	RAPID3 (0-30)
2	0.7	7	2.3	12	4	17	5.7	22	7.3	27	9				Near Remission <3.01
3	1	8	2.7	13	4.3	18	6	23	7.7	28	9.3				Low Severity 3.01-6.0
4	1.3	9	3	14	4.7	19	6.3	24	8	29	9.7				Moderate Severity 6.01-12.0
5	1.7	10	3.3	15	5	20	6.7	25	8.3	30	10				High Severity >12.0