Arthritis and Rheumatology Consultants, P.A.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Sex: Male / Female / Other Home Phone _____ Work Phone _____

Address _____City_____State_____Zip_____

Ethnicity: Latino or Hispanic / Not Hispanic / Unknown Primary Language: _____

Employer _____ Occupation _____

Name of Spouse _____ Employer _____ Work Phone # _____

INSURANCE INFORMATION

Insurance Plan: *(please complete requested information below*)

_____

Name of Insurance Address

Group # _____ ID # _____ Copay $_____

Policy Holder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance: _____

Name Address

Group # _____ ID # _____ Copay $_____

Policy Holder Name _____ Date of Birth _____ Relationship _____

ADDITIONAL INFORMATION

Emergency Contact (not living with you) _____

Relationship _____ Home Phone # _____ Work Phone # _____

Primary Physician _____ Clinic _____ Phone _____

Referring Physician _____ Clinic _____ Phone _____

By signing below I acknowledge this information is correct. I authorize my insurance company to remit payment directly to my physician for services rendered. I agree that my medical records for treatment may be released to my insurance company for claims processing. I authorize the release and disclosure of any and all of my medical records to my primary care and referring physician.

I am aware that I am responsible for any balance not paid by my insurance, and I agree to pay all statements upon receipt.

Signature _____ Date _____

Printed Name _____ Relationship to patient _____

ARTHRITIS AND RHEUMATOLOGY CONSULTANTS, P.A.

NAME_____ **DATE OF BIRTH**_____

DATE OF APPOINTMENT_____

PAST HISTORY: Have you ever had:

Polio	yes	no
Tuberculosis	yes	no
Exposure to TB	yes	no
Hepatitis B or C	yes	no
Kidney disease	yes	no
Asthma	yes	no
Arthritis	yes	no
High blood pressure	yes	no
Anemia	yes	no
Nosebleeds	yes	no
Cancer	yes	no
Type_____		
Broken bones	yes	no
Where_____		
Meningitis	yes	no
Bronchitis	yes	no
Pneumonia	yes	no
Rheumatic fever	yes	no
Hives	yes	no
Emphysema	yes	no
Back trouble	yes	no
Heart disease	yes	no
Bleeding tendency	yes	no
Ulcers	yes	no
Diabetes	yes	no
Blood transfusion	yes	no

ALLERGIES TO MEDICATION

Penicillin	yes	no
Sulfa	yes	no
Other_____		

OPERATIONS: please describe

Tonsils	yes	no
Appendix	yes	no
Gallbladder	yes	no
Breast_____	yes	no
Uterus/Ovary_____	yes	no
Prostate_____	yes	no
Joints_____	yes	no
Thyroid_____	yes	no
Hernia	yes	no
Hemorrhoids	yes	no
Heart_____	yes	no

OB/GYN

Number of pregnancies_____

Number of miscarriages_____

Number of births_____

Date of last menstrual period? _____

IMMUNIZATIONS

Tetanus	yes	no
BCG	yes	no
Pneumovax	yes	no
Flu this year	yes	no
Hepatitis	yes	no
Other	yes	no

SOCIAL HISTORY

Do you smoke?	yes	no
How much_____		
Do you use alcohol?	yes	no
How much_____		
Do you use: intervenous drugs	yes	no
caffeinated beverages	yes	no
How much_____		

Marital status S M W D Separated

Children_____

Employment_____

FAMILY HISTORY

Lupus	yes	no
Scleroderma	yes	no
Crohns/Ulcerative colitis	yes	no
Arthritis	yes	no
Heart Disease	yes	no
Lung Disease	yes	no
Tuberculosis	yes	no
High blood pressure	yes	no
Kidney disease	yes	no
Cancer	yes	no
Diabetes	yes	no
Gout	yes	no
Thyroid trouble	yes	no
Other_____		

RHEUMATOLOGIC: Have you ever had

Blood clots	yes	no
Miscarriage	yes	no
Photosensitive rash	yes	no
Psoriasis	yes	no
Tight skin hands/feet	yes	no
White/red/blue color change of hands	yes	no
and feet with cold	yes	no
Patchy hair loss	yes	no
New lumps or bumps	yes	no
Where_____		
Dry eyes.mouth	yes	no
Recurrent mouth/nose ulcers	yes	no
Persistent swollen glands	yes	no
Sharp pain with deep breath	yes	no

Please See Other Side

Have any of these been a problem in the past 6 months:

GENERAL

Fatigue	yes	no
Marked weight change	yes	no
Night sweats	yes	no
Chills	yes	no
Other_____	yes	no

SKIN

Rash	yes	no
Change in hair	yes	no
Change in nails	yes	no
Other_____		

EYES

Trouble seeing	yes	no
Eye pain	yes	no
Red eyes	yes	no
Double vision	yes	no
Other_____		

EARS

Loss of hearing	yes	no
Ringing in ears	yes	no
Discharge	yes	no
Pain or swelling	yes	no
Other_____		

NOSE

Loss of smell	yes	no
Obstruction	yes	no
Nosebleeds	yes	no
Other_____		

HEART AND LUNGS

Cough	yes	no
Sputum (phlegm)	yes	no
Wheezing	yes	no
Chest pain	yes	no
Pain on breathing	yes	no
Shortness of breath	yes	no
Swelling of ankles	yes	no
Palpitations	yes	no
Other_____		

PSYCHIATRIC

Feelings of depression	yes	no
Feelings of anxiety	yes	no

DIGESTIVE SYSTEM

Change in appetite	yes	no
Difficulty in swallowing	yes	no
Heartburn	yes	no
Abdominal pain	yes	no
Nausea	yes	no
Vomiting	yes	no
Rectal bleeding	yes	no
Tarry stools	yes	no
Jaundice	yes	no
Constipation	yes	no
Diarrhea	yes	no
Other_____		

GENITO-URINARY

Increased urinary frequency	yes	no
Unable to hold urine	yes	no
Urinary pain/burning	yes	no
Blood in urine	yes	no
Other_____		

ENDOCRINE

Sensitivity to heat/cold	yes	no
Other_____		

THROAT

Soreness	yes	no
Hoarseness	yes	no
Other_____		

MUSCULOSKELETAL:

Muscle weakness	yes	no
Pain in joints	yes	no
Swollen joints	yes	no
Stiffness	yes	no
Deformity of joints	yes	no
Morning stiffness	yes	no
How long_____		
Stiffness with inactivity	yes	no
Other_____		

NERVOUS SYSTEM

Headaches	yes	no
Dizziness	yes	no
Seizures	yes	no
Difficulty sleeping	yes	no
Persistent numbness/tingling	yes	no
Where _____		
Walking difficulty/falls	yes	no

FOR CLINIC USE ONLY:

Reviewed by:_____

Date: _____

Please See Other Side

We have a computerized medical record that will store your medical history in a secure electronic format. We will be building your medical record as you come in for your appointment.

To help build your record accurately we are asking you to complete this list of all your current medications. This list should include the medication name, strength, and dose. Please include any over the counter medications, vitamins, and herbal supplements. The first entry is an example of how to list your current medications. We ask that you fill this out and mail it back to us as soon as possible so that we may have this information available in your record for your next appointment.

Your Name: _____ Date of Birth: _____

Please identify your Primary Care Physician and Clinic: _____

Please provide us with the name and telephone number of your preferred pharmacy:

_____

Name City Phone Number

NAME OF MEDICATION	STRENGTH	DOSE
Prednisone (EXAMPLE)	*5mg*	*1 tablet every day*