ROUTINE ASSESSMENT OF PATIENT INDEX DATA

Name: _____

Date of Birth: _____ **Today's Date:** _____

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:				
OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
b. Get in and out of bed?	____0	____1	____2	____3
c. Lift a full cup or glass to your mouth?	____0	____1	____2	____3
d. Walk outdoors on flat ground?	____0	____1	____2	____3
e. Wash and dry your entire body?	____0	____1	____2	____3
f. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
g. Turn regular faucets on and off?	____0	____1	____2	____3
h. Get in and out of a car, bus, train, or airplane?	____0	____1	____2	____3
i. Walk two miles or three kilometers, if you wish?	____0	____1	____2	____3
j. Participate in recreational activities and sports as you would like, if you wish?	____0	____1	____2	____3
k. Get a good night's sleep?	____0	____1.1	____2.2	____3.3
l. Deal with feelings of anxiety or being nervous?	____0	____1.1	____2.2	____3.3
m. Deal with feelings of depression or feeling blue?	____0	____1.1	____2.2	____3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0=10):

3. PTGE (0-10):

RAPID3 (0-30):

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

NO PAIN PAIN AS BAD AS IT COULD BE

● ●

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

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 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

Arthritis and Rheumatology Consultants, P.A.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Primary Phone _____ Day Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Birth Gender: Male / Female /Other

Current Gender _____ Permission for Nurse to leave a detailed Voice Message: Yes /No

Race (One or more categories may be marked)
☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other _____ ☐ Declined ☐ Unavailable/Unknown

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

INSURANCE INFORMATION

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

Primary Insurance _____ Address _____

Group # _____ ID # _____

Secondary Insurance: _____
Name Address

Group # _____ ID # _____

ADDITIONAL INFORMATION

Emergency Contact _____ Relationship _____

Primary Phone # _____ Secondary 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.

Phone: (952) 893-1959
Fax: (952) 893-1954
www.rheummds.com

Date of Appointment: _____ with Dr. _____.

Your Full Name: _____ Date of Birth_____

_____

Primary Physician Clinic Phone

_____

Referring Physician Clinic Phone

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

_____

Name of Pharmacy Phone Number

_____

Address of Pharmacy

Please report your current medications by name, strength, and dose. Please include any over the counter medications, vitamins and herbal supplements. The bottom of this letter includes a form for you to list this information. The first entry is an example of how to list your current medications.

NAME OF MEDICATION	STRENGTH	DOSE
Prednisone (Example)	*5 MG*	*1 tablet every day*

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

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

Arthritis and Rheumatology Consultants, P.A.

Effective August 1, 2020

Failed Appointment Policy

Failed appointments with Arthritis and Rheumatology Consultants, P.A. waste valuable time and deprive you and others of treatment.

Failed appointments are defined as those for which a patient does not appear or the patient shows up more than 5 minutes late (unless the office is notified of a late arrival time and the doctor is able to see the patient).

If you are unable to keep your appointment, it is the policy of this office that you call to cancel and/or reschedule your appointment **24 hours prior to each scheduled appointment time.** Reminder calls for appointments are a courtesy only. Patients are responsible for remembering their scheduled appointments.

We understand that emergencies can happen and may be out of your control. Therefore, your emergency or situation will be reviewed on a case by case basis. You are still required to contact the office in the event you are unable to keep your appointment.

In the event you do not call to cancel/reschedule your appointment 24 hours prior to your appointment time, it will be considered a **Failed Appointment.** You will be charged $50.00* per missed appointment. That must be paid before the office can re-appoint.

Your signature below acknowledges that you have read and understand the above policy.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed Name Date Of Birth

*The missed appointment charge of $50.00 is **not covered** by insurance.

Arthritis and Rheumatology Consultants, P.A.

Authorization to Release Medical Information to Friends and Family Members

Name of Patient (Please Print): _____

Birth Date: _____

In accordance with Federal government privacy rules implemented through the Healthcare Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of Arthritis and Rheumatology Consultants, P.A. to discuss your condition with members of your family or other individuals that you designate, we must obtain your express written consent prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

This authorization will expire 365 days from the date of signing. You have the right to revoke this authorization, in writing, at any time.

_____ I authorize Arthritis and Rheumatology Consultants, P.A. to discuss my lab results and medical care (including but not limited to future appointments, treatment plans, prognosis, etc.) with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

If you do not wish any information to be released, please initial here-_____

_____ _____
Patient Signature Today's Date