Appt Date:

Advanced Rheumatology and Arthritis Center

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

Contact Information

Please review the information below and alert the front desk if this is incorrect or has changed

E-mail Address: Home Phone: Mobile

Address: Additional address info:

City: ST: Zip:

Emergency Contact

(Please fill out boxes below)

First name: Last name:

Day # Work # Cell #

Relationship: ☐ Spouse ☐ Daughter ☐ Son ☐ Mother ☐ Father ☐ Sister

☐ Other Please list here

Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life partner

Race: ☐ White ☐ African-American ☐ Asian ☐ Unknown

☐ American Indian/Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Refused/Declined

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your tobacco use history?

Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown

☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

	Current	Former	Never	Amount per day:	Number of Years:
Cigarettes	☐	☐	☐	Packs	
Cigar	☐	☐	☐	Cigars	
Pipe	☐	☐	☐	Pipes	

	Current	Former	Never	Amount per day:	Number of Years:
Chewing	☐	☐	☐	Dippers	
Snuff	☐	☐	☐	Dippers	
Smokeless (Electronic)	☐	☐	☐	Units	

Second-hand smoke exposure: ☐ Yes ☐ No

What is your alcohol use history?

Drinks alcohol: ☐ Yes ☐ No ☐ Formerly

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Drinks caffeine: ☐ Yes ☐ No

Number of drinks:

329-1977-20-124

Past Rheumatologic History

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

- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Childhood Arthritis
- ☐ Gout
- ☐ Psoriatic Arthritis
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Past Fracture History

R	L	B	Please list location of fracture.	YEAR
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

Past Medical History

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

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer

Type:

- ☐ Cataracts
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gall Stones/ Digestive Disease
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High B/P
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Goiter/Thyroid Disease
- ☐ Iritis/Scleritis
- ☐ Jaundice Live Disease
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Shingles
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Tuberculosis

Past Surgical History

Have you ever had one of the following surgeries listed below (check & enter year)

	Year		Year		Year
☐ Angioplasty		☐ Gastric Bypass		☐ Pacemaker	
☐ Appendectomy		☐ Hernia Repair		☐ Small Bowel Resection	
☐ Back Surgery		☐ Hip Replacement		☐ Thyroidectomy	
☐ Coronary Artery Bypass Surgery		Location: R ☐ L ☐ B ☐		☐ Tonsillectomy	
☐ Carpal Tunnel Release		☐ Knee Replacement		**Females Only**	
☐ Cholecystectomy		Location: R ☐ L ☐ B ☐		☐ Caesarean Section	
☐ Cataracts		☐ Liver Biopsy		☐ Hysterectomy	
☐ Colostomy		☐ Open Reduction Internal Fixation		☐ Mastectomy	
				☐ Breast Biopsy	

Past Treatment History

Have you ever had one of the following treatments listed below (check & enter year)

	Year		R	L	B	Year
☐ Acupuncture		☐ Cortisone Joint Injection	☐	☐	☐	
☐ Chiropractic		☐ Hyalgan/Supartz/Euflexxa/ Joint Injection	☐	☐	☐	
☐ Physical Therapy		☐ Synvisc Joint Injection	☐	☐	☐	

Family History

Do you know of any blood relative who has or had: (check if "yes")

☐ Alcoholism	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Ankylosing Spondylitis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Antiphospholipid Syndrome	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Crohn's Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Childhood Arthritis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Dermatomyositis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Illegal Drug Abuse	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Gout	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Osteoarthritis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Osteoporosis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Polymyositis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Prescription Drug Abuse	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Psoriasis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Psoriatic Arthritis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Lower Back Pain	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Lupus	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Mixed Connective Tissue Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Sarcoid	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Scleroderma	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Sjogrens	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Tuberculosis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Ulcerative Colitis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Wegener's\GPA	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter

Allergies

Are you allergic to any of the following: (check if "yes")

☐ Amoxicillin	☐ Erythromycin	☐ Iodine	☐ Penicillin
☐ Aspirin	☐ Ibuprofen	☐ Insulin	☐ Sulfa
☐ Other Allergies	☐ No Known Allergies		

Prior Testing

When was your last bone density scan?

M M – D D – Y Y Y Y ☐ Check here if date is approx.

Results:

☐ Normal

☐ Abnormal

What was the date of your last Tuberculosis skin test?

M M – D D – Y Y Y Y ☐ Check here if date is approx.

Results:

☐ Positive

☐ Negative

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Test, TC1

Review of Symptoms

Are you currently experiencing any of the following symptoms?

Constitutional Symptoms

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin

- ☐ Rashes
- ☐ Psoriasis
- ☐ Hives
- ☐ Dry Skin
- ☐ Itching
- ☐ Hair Loss
- ☐ Skin Color Change
- ☐ Sun Sensitivity
- ☐ Nail Changes
- ☐ Dandruff
- ☐ Scalp Tenderness

Neurologic

- ☐ Dizziness
- ☐ Numbness
- ☐ Loss of Balance
- ☐ Memory Loss
- ☐ Burning in Extremities
- ☐ Headache
- ☐ Tremors

Cardiovascular

- ☐ Palpitations
- ☐ Chest Pain
- ☐ Edema
- ☐ Murmur
- ☐ High Blood Pressure

Respiratory

- ☐ Shortness Of Breath
- ☐ Cough

Respiratory

- ☐ Blood In Sputum
- ☐ Night Sweats
- ☐ Wheezing

Eyes

- ☐ Dry Eyes
- ☐ Inflammation/Redness
- ☐ Double Vision
- ☐ Blurry Vision
- ☐ Gritty feeling in Eyes
- ☐ Pain in Eyes
- ☐ Loss of Vision
- ☐ Tearing

Hematologic/Lymph

- ☐ Easy Bruising
- ☐ Anemia
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Gland
- ☐ Blood Clots

Gastrointestinal

- ☐ Rectal Bleeding
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn

Psychiatric

- ☐ Anxiety
- ☐ Mood Changes
- ☐ Sleep Cycle Shift
- ☐ Depression
- ☐ Irritability

Endocrine

- ☐ Thirsty
- ☐ Gout
- ☐ Uncontrolled hunger
- ☐ Face shape Change

Genitourinary

- ☐ Burning w/ Urination
- ☐ Blood in Urine

ENT

- ☐ Ear Ache
- ☐ Dry Mouth
- ☐ Jaw Pain
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Sores in Mouth
- ☐ Runny nose
- ☐ Bad Taste in Mouth
- ☐ Loss of Appetite
- ☐ Sore Throat

Musculoskeletal

- ☐ Pain when Walking relieved by rest
- ☐ Joint Pain
- ☐ Joint Swelling/Stiffness
- ☐ Loss of Motion
- ☐ Muscle Stiffness
- ☐ Muscle Cramps
- ☐ Fractures
- ☐ Difficulty doing normal activities of daily living
- ☐ Morning Stiffness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Height loss
- ☐ Decreased Strength

Appt Date: 02/22/2022

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

This questionnaire includes information not available from blood test, x-ray, or any other source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can by yourself, if you need help, please ask. There are no right or wrong answers. Please answer exactly as you feel. Thank you.

1. Please place a (x) in 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, include 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 grass?	☐ 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 or out 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 nights sleep?	☐ 0	☐ 1	☐ 2	☐ 3
l. Deal with feeling of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition OVER THE PAST ONE WEEK? Please indicate below how severe you pain has been:

NO PAIN ☐ 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 PAIN AS BAD AS IT COULD BE

3. Please check the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
NECK	☐ 0	☐ 1	☐ 2	☐ 3	LUMBAR	☐ 0	☐ 1	☐ 2	☐ 3

4. Consider all the ways in which illness and health conditions may effect you at this time, please indicate how you are doing:

Very Well ☐ 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 Very Poorly

Patient Name:

Appt Date: 02/22/2022

Birth Date:

Gender:

Rendering Provider:

MRN:

Medications

Please list below all drugs and medications taken over the last week(including birth control pills, aspirin and any kind of drug or medication bought without a prescription.)

Name of Drug or Medicine	Dosage If Known	How Many Per Day	How Helpful is It			Any side Effects		If Yes was it		
			(A lot)	(Some)	(None)	(Yes)	(No)	(GI)	(Skin)	(Other)
1			☐	☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐	☐
11			☐	☐	☐	☐	☐	☐	☐	☐
12			☐	☐	☐	☐	☐	☐	☐	☐
13			☐	☐	☐	☐	☐	☐	☐	☐
14			☐	☐	☐	☐	☐	☐	☐	☐
15			☐	☐	☐	☐	☐	☐	☐	☐
16			☐	☐	☐	☐	☐	☐	☐	☐
17			☐	☐	☐	☐	☐	☐	☐	☐

Preferred Pharmacy

Pharmacy Name:_____ **Phone:**_____ **Fax:**_____

Address:_____ **City:**_____ **ST:**_____ **ZIP:**_____

Sign:_____ Date:_____