Patient Registration

TODAYS DATE:_____

Patient Information

COMPLETE PARENT/LEGAL GUARDIAN FORM IF PATIENT IS A MINOR

LAST NAME _____FIRST NAME_____

MI _____ DATE OF BIRTH _____/_____/_____ SEX M F

ADDRESS_____

CELL PHONE: _____ HOME PHONE:_____

EMPLOYER NAME _____

EMP STATUS: FULL TIME / PART TIME STUDENT STATUS: FULL TIME / PART TIME

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOW

ETHNICY _____ RACE _____

EMAIL_____

EMERGENCY CONTACT: _____

RELATIONSHIP _____

HOME PHONE: _____CELLPHONE: _____

MAY WE CONTACT THIS PERSON IF UNABLE TO REACH THE PATIENT □ YES □NO

INSURANCE INFORMATION

ONLY FILL OUT THIS SECTION IF A HARD COPY OF YOUR INSURNACE CARD WAS NOT PROVIDED TO THE STAFF.

PRIMARY INSURANCE:

INSURANCE CO. NAME_____

NAME ON CARD: _____

POLICY HOLDER/SUBSCRIBER OF INSURANCE (RELATION TO PATIENT):

SELF SPOUSE PARENT /GUARDIAN OTHER

MEMBER I.D. # _____ GROUP # _____

SECONDARY INSURANCE:

INSURANCE CO. NAME_____

NAME ON CARD: _____

POLICY HOLDER/SUBSCRIBER OF INSURANCE (RELATION TO PATIENT):

SELF SPOUSE PARENT /GUARDIAN OTHER

MEMBER I.D. # _____ GROUP # _____

Rheumatology New Patient Intake Form

Primary reason for your visit today?

Describe briefly your ***present*** symptoms:

_____

_____

_____

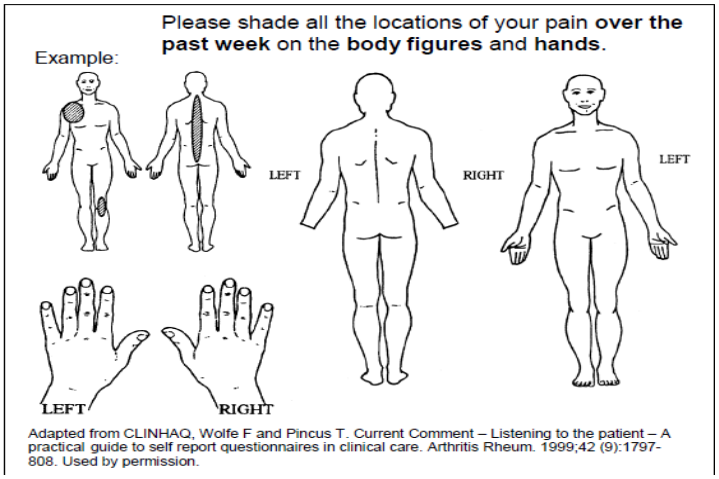
Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, and injections.

_____

_____



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.

Please list the other practioners you have seen for this problem:

_____ _____

_____

Primary Doctor's Name:_____ Referring Doctors Name: _____

Preferred Pharmacy: _____

Specialty or Mail Order Pharmacy:_____

How did you hear about us/Who referred you? _____

Allergies:_____

What medications do you take (prescription and over-the-counter)?

1. _____ 7._____

2. _____ 8._____

3. _____ 9._____

4. _____ 10._____

5. _____ 11._____

6. _____ 12._____

Do you currently have or *have you ever had* the following: (circle if "yes")

High blood pressure	Epilepsy(seizure)	Osteoporosis or osteopenia	Kidney disease
High cholesterol	Liver disease	Diabetes	H.Pylori infection
Heart attack or heart failure	Stomach ulcers	Thyroid problem	cataracts
Stroke	FRACTURES	Cancer	Tuberculosis	Psoriasis

Crohns disease/ulcersative colitis

Other medical diagnoses/problems

_____

_____

Surgery or procedures Year Reason

_____

_____

_____

For women:

How many times have you been pregnant? _____ How many miscarriages or abortions? _____

What type of contraception (birth control) do you use currently?

Date of last menstrual cycle: _____ Current or past use of female hormones? Y N

Have **you or anyone in your family** ever been diagnosed with any of the following? (Check if "yes.")

	Self	Family (What relation?)		Self	Family (What relation?)
Arthritis (unknown type)			Lupus (SLE)		
Rheumatoid arthritis			Ankylosing spondylitis		
Osteoarthritis			Psoriatic arthritis		
Gout			Childhood arthritis		
Vasculitis			Scleroderma		
Dermatomyositis or polymyositis			Uveitis (inflammatory eye disease)		

Past Exams/Evaluations: Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last bone density: ____/____/___ Date of last Tuberculosis Test: ____/____/____

Do you smoke or use smokeless tobacco products (eg, "chew")? Yes No Past (When did you quit?) _____

Do you drink alcohol? Yes No Past (When did you quit?) _____

If yes, how often? Daily Weekly Monthly or less

Have you ever used "street" drugs, including by injection? Yes No Past (Ever) [When did you quit?] _____

Do you exercise?: Yes No (If yes, what type and how often?) _____

With whom do you currently live? _____

Occupation: _____

Have you had any of these symptoms

General	Musculoskeletal
☐ Fevers	☐ Finger/toe color changes
☐ Weight gain or loss: How much?	☐ Fingertip ulcers
☐ Swollen lymph nodes: Where?	☐ Shoulder ☐ pain ☐swelling
☐ Fatigue	☐ Elbow ☐ pain ☐swelling
	☐ Wrist/hand ☐ pain ☐swelling
HEENT	☐ Hip ☐ pain ☐swelling
☐ Double or blurry vision	☐ Knee ☐ pain ☐swelling
☐ Dry eyes or mouth	☐ Ankle/foot ☐ pain ☐swelling
☐ Snoring	☐ Neck/back pain
☐ Mouth or nose ulcers/sores	☐ Muscle aches
☐ Dry cough	☐ Morning stiffness: How long?
☐ Sore throats	
☐ Nasal congestion	Neurologic
	☐ Headache
Cardiac	☐ Numbness or tingles: Where?
☐ Chest pain	☐ Burning pain: Where?
☐ Racing heart beat or palpitations	☐ Weakness: What body part?
☐ Foot/leg swelling	☐ Passing out
Pulmonary	Dermatologic
☐ Shortness of breath	☐ Rash
☐ Coughing up blood	☐ Sun sensitivity
☐ Coughing up phlegm	☐ Hair falling out
	☐ Mouth/nose ulcers
Gastrointestinal	☐ Nail pits/dents
☐ Abdominal pain	☐ Eczema
☐ Nausea and/or vomiting	☐ Dandruff
☐ Diarrhea	
☐ Bloody stool	Hematologic
☐ Hemorrhoids	☐ Anemia
☐ Dark black stool	☐ Low platelets
	☐ Easy bruising
Genitourinary	
☐ Buring with urination	Psychologic
☐ Blood in urine	☐ Excessive worry/anxiety
☐ Foamy urine	☐ Depressed mood
☐ Kidney stones	☐ Difficulty falling/staying asleep

PLEASE CIRCLE ANY MEDICATION(S) YOU HAVE TAKEN IN THE PAST OR CURRENTLY.

Pain medications

Ibuprofen (Motrin, Advil)
Naproxen (Naprosyn, Aleve)
Meloxicam (Mobic)
Diclofenac (Voltaren, Athrotec)
Celecoxib (Celebrex)
Acetaminophen (Tylenol)
Hydrocodone (Lortab, Norco)
Tramadol (Ultram)
Piroxicam (Feldene)
Rofecoxib (Vioxx)
Aspirin (full strength)
Sulindac (Clinoril)
Indomethacin (Indocin)
Codeine (Vicodin, Tylenol #3 or #4)
Oxycodone (Oxycontin, Roxicodone)

Oral immunosupressants (ie, pills)

Gold pills or shots
Methotrexate (Rheumatrex)
Azathioprine (Imuran)
Apremilast (Otezla)
Steroids (prednisone, methylprednisolone, dexamethasone, Rayos, "dose pack")
Olumiant (baricitinib)
Hydroxychloroquine (Plaquenil)
Sulfasalazine (Azulfidine)
Tofacitinib (Xeljanz)
Cyclophosphamide (Cytoxan)
Mycophenylate mofetil (CellCept)

Injectable or infusion immunosuppressants

Cyclophosphamide (Cytoxan)
Adalimumab (Humira)
Certolizumab (Cimzia)
Abatacept (Orencia)
Ustekinumab (Stelara)
Canakinumab (Ilaris)
Rituximab (Rituxan)
Etanercept (Enbrel)
Infliximab (Remicade)
Golimumab (Simponi)
Toculizumab (Actemra)
Kinaret (Anakinra)
Corticotropin (Acthar)
Others (please name)

Gout medication

Colchicine (Colchrys)
Probenacid (Benemid)
Pegloticase (Krystexxa)
Allopurinol (Zyloprim, Lopurin)
Febuxostat (Uloric)
Rasburicase (Elitek)

Osteoporosis medication

Alendronate (Fosamax)
Risedronate (Actonel)
Teriparatide (Forteo)
Calcitonin (Calcimar, Miacalcin)
Ibandronate (Boniva)
Zolendronate (Reclast)
Denosumab (Prolia)
Estrogen (Premarin, Vivelle)

Fibromyalgia or chronic pain medications

Amitriptyline (Elavil)
Pregabalin (Lyrica)
Milnacipran (Savella)
Carisoprodol (Soma)
Gabapentin (Neurontin)
Duloxetine (Cymbalta)
Cyclobenzaprine (Flexeril)
Methocarbamol (Robaxin)