Arthritis & Osteoporosis Clinic

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Board Certified in Rheumatology
Board Certified in Internal Medicine

Dear Prospective Patient:

To allow us to do a better job in assessing your musculoskeletal and/or other medical problems, we use the attached questionnaire. It also addresses medications, which I must know in order to prescribe medicine that will not interfere with what you currently take. Please be patient, as I know the form is long!

Please mail the completed questionnaire back to us in time for review before your appointment, and be here 15 minutes early to fill out other forms. Your initial visit appointment time in our schedule has been reserved just for you. You must give us at least a 24-hour notice of cancellation; otherwise, there will be a $150.00 cancellation fee. Our office tries to run on schedule unless emergencies arise.

Please note the following:

1. **Please realize that I have been in solo practice in East Texas for almost 20 years. We have a growing waiting list for new patients. I am trying my best to accommodate all of our patients' needs, but with the growing waiting list, I am focusing my efforts on seeing/evaluating new patients. Therefore, my Nurse Practitioners (trained and supervised by me) will be seeing an increasing number of return patients. We are fortunate and blessed to have a growing practice, but with my solo status, there is no way for me to personally see everyone. I consider my Nurse Practitioners to be an extension of myself; they are fully licensed and endorsed by Medicare and other insurance companies as "Physician Extenders."**
2. We do not evaluate anyone for disability, Workman's Compensation, or functional capacity problems.
3. This is a referral/consulting practice and you should have a primary-care physician.
4. The practice is strictly outpatient-based with minimal hospital involvement. If you require hospital admission, this should be done through your primary physician, emergency room physician, etc.
5. Prescriptions will **only** be filled during regular office hours and not at night or on weekends. For your own safety, please be sure you are current on all required lab work.
6. With rare exception, all telephone questions are handled by our nurses during normal business hours, who are well-trained in rheumatological care. If you have any after-hours issues you may leave a message with our answering service. Your call will be returned during normal business hours. If it is an emergency please call 911 or go the emergency room.

We accept most insurance, and please remember to bring your insurance cards. We file your insurance as a courtesy, but it is your responsibility to ensure that your insurance company pays their portion of your bill.

For all visits, note any deductibles that have not been paid, as well as any co-payment, are due at the time of service. If your insurance requires a referral, you must make sure that we have received your referral number at least 24 hours before your appointment. (Please contact us before your appointment to verify we have the number.) No payment is required for Medicare with a supplement. For Medicare without a supplement, 20% of your bill is due at the time of service.

We are in solo practice and we appreciate your adherence to the above. Your accurate completion of the questionnaire is much appreciated. We will try to do our very best to help you, and thank you for choosing us!

Sincerely,

William G. Brelsford, M.D., F.A.C.P., F.A.C.R.

Updated 7-21-10

ARTHRITIS & OSTEOPOROSIS CLINIC OF EAST TEXAS,P.A. MEDICAL HISTORY

Date of first Appointment: ____ / ____ / ____ (MONTH / DAY / YEAR)

Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN)

Birthdate: ____ / ____ / ____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#)

Age: _____ Sex: ☐ F ☐ M

_____ (CITY / STATE / ZIP)

Telephone: Home ( ) _____ - _____

Work ( ) _____ - _____

Do you live in a: ☐ Assisted Living Facility ☐ Nursing Home ☐ Neither

Are you under the care of a Home Health Agency? ☐ Yes ☐ No

Race: ☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Asian/Pacific Islander

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

Name of physician providing your general medical care: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No. If yes, name _____

Describe briefly your present symptoms: _____

Date symptoms began (approximately) _____ Diagnosis given (please list) _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later) _____

Please list the names of other doctors you have seen for this problem: _____

Because of health problems, do you have difficulty with any of the following: (Please check one cloumn)

	Usually	Sometimes	No
Using your hands to grasp small objects?(buttons, toothbrush, pencil, etc.)			
Walking?			
Climbing stairs?			
Descending stairs?			
Sitting down?			
Getting up from a chair?			
Touching your feet while seated?			
Reaching behind your back?			
Reaching behind your head?			
Dressing yourself?			
Going to sleep?			
Bathing?			
Eating?			
Working?			
Getting along with other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)			

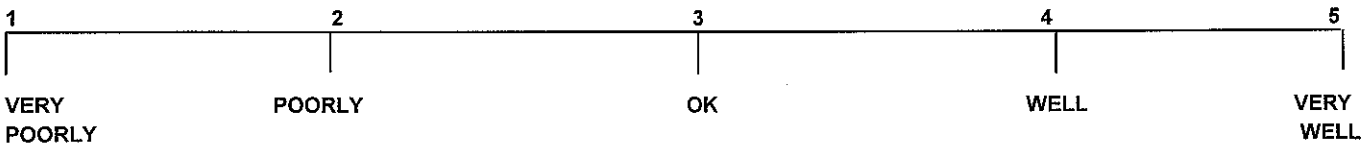
Are you receiving disability? _____ Yes _____ No

Are you applying for disability? _____ Yes _____ No

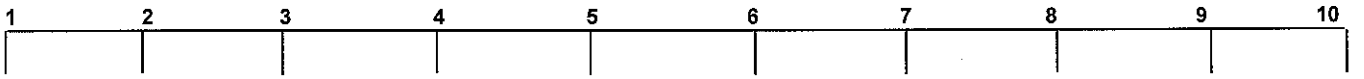
Do you have a medically related lawsuit pending? _____ Yes _____ No

What is the hardest thing for you to do? _____

On the scale below, circle a number which best describes your situtation: Most of the time, I function...



On the scale below circle a number which describes your pain: Most of the time I have...



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. Record your comments in the space provided.

Drug Names/Dosage	Length of Time	Postive Results of Medications			Reactions
		A Lot	Some	Not at all	
1. Aspirin					
2. Bextra					
3. Aspirin- contaning product					
4. Celebrex					
5. Mobic					
6.Tylenol (plain)					
7. Tylenol with codeine					
8. Vioxx					
9. Clinoril					
10. Feldene					
11. Indocin					
12. Motrin / Rufen / Ibuprofen					
13. Nalfon					
14. Naprosyn/Naprelan					
15. Tolectin					
16. Voltaren					
17. Ansaid					
18. Lodine					
19. Relafen					
20. Daypro					
21. Cortisone / Prednisone					
22. Benemid					
23. Colchicine					
24. Zylpprim / Lopurin / Allopurinol					
25. Gold (shots or pills)					
26. Plaquenil					
27. Penicillamine					
28. Methotrexate / Rheumatrex					
29. Imuran					
30. Cytoxan					
31. Arava					
32. Enbrel					
33. Remicade					
34. Narcotics					
35. Other					

SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

GENERAL
- _____ Recent weight gain/amount
- _____ Recent weight loss/amount
- _____ Fatigue/tiredness
- _____ Weakness
- _____ Fever

NERVOUS SYSTEM
- _____ Headaches
- _____ Dizziness
- _____ Fainting
- _____ Muscle spasm
- _____ Loss of consciousness
- _____ Numbness or tingling of hands and/or feet
- _____ Memory loss

EARS
- _____ Ringing in ears
- _____ Loss of hearing

EYES
- _____ Pain
- _____ Redness
- _____ Loss of vision
- _____ Double or blurred vision
- _____ Dryness
- _____ Feels like something in eye

NOSE
- _____ Nosebleeds
- _____ Loss of smell
- _____ Sores on nose

MOUTH
- _____ Sore on tongue
- _____ Bleeding gums
- _____ Sores in mouth
- _____ Loss of taste
- _____ Dryness

THROAT
- _____ Frequent sore throats
- _____ Hoarseness
- _____ Difficulty in swallowing

Date of last eye examination _____
Date of last chest x-ray _____
Date of last Tuberculosis test _____

NECK
- _____ Swollen glands
- _____ Tender glands

HEART AND LUNGS
- _____ Pain in chest
- _____ Irregular heart beat
- _____ Sudden changes in heart beat
- _____ Shortness of breath
- _____ Difficulty in breathing at night
- _____ Swollen legs or feet
- _____ High blood pressure
- _____ Heart murmurs
- _____ Cough
- _____ Coughing of blood
- _____ Wheezing
- _____ Night sweats

STOMACH AND INTESTINES
- _____ Nausea
- _____ Vomiting of blood or coffee ground material
- _____ Stomach pain relieved by food or milk
- _____ Yellow Jaundice
- _____ Increasing constipation
- _____ Persistent diarrhea
- _____ Blood in stools
- _____ Black stools
- _____ Heartburn

KIDNEY / URINE / BLADDER
- _____ Difficult urination
- _____ Pain or burning on urination
- _____ Blood in urine
- _____ Cloudy, "smoky" urine
- _____ Pus in urine
- _____ Discharge from penis/vagina
- _____ Frequent urination
- _____ Getting up at night to pass urine
- _____ Vaginal dryness
- _____ Rash/ulcers
- _____ Sexual difficulties
- _____ Prostate trouble

BLOOD
- _____ Anemia
- _____ Bleeding tendency

SKIN
- _____ Easy bruising
- _____ Redness
- _____ Rash
- _____ Hives
- _____ Sun sensitive (sun allergy)
- _____ Tightness
- _____ Nodules/bumps
- _____ Hair loss more than norma
- _____ Color changes of hands or feet in the cold
- _____ Psoriasis

MUSCLES / JOINT/BONES
- _____ Morning stiffness
  Lasting how long?
  _____ Minutes
  _____ Hours
- _____ Joint pain
- _____ Muscle weakness
- _____ Muscle tenderness
- _____ Joint swelling

SLEEP
Do you sleep well? ☐ Yes ☐ No
Do you get enough sleep? ☐ Yes ☐ No
How many hours? _____
Trouble getting to sleep? ☐ Yes ☐ No
Do you awaken during the night?
☐ Yes ☐ No _____ # of times
Why? _____
Do you awaken too early? ☐ Yes ☐ No
Do you wake feeling tired? ☐ Yes ☐ No

HABITS
Do you drink coffee? ☐ Yes ☐ No
☐ Caffineted ☐ Decaffineted
Cups per day? _____
Do you smoke? ☐ Yes ☐ No ☐ Past
Cigarettes per day? _____
Do you drink alcohol? ☐ Yes ☐ No
If so, how much per day or week? _____

Do you use drugs for reasons that are not medical? If so, please list: _____

Do you have any metal in your body? ☐ No ☐ Yes Type: Pacemaker_____ Cochlear implants_____ Shrapnel_____ Joint replacement_____ Pain Pump_____

FOR WOMEN ONLY
Age when periods began _____ Periods regular ☐ Yes ☐ No How many days apart _____ Date of last period _____
Date of last pap smear _____ Date of last breast exam _____ Date of last mammogram _____
Planning pregnancy? ☐ Yes ☐ No

PAST PERSONAL HISTORY

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

Cancer _____	Heart problems _____	Asthma _____	Nervous stomach _____
Cataracts _____	Diabetes _____	Stomach ulcers _____	Nervous breakdown _____
Anxiety / nervousness _____	Rheumatic fever _____	Bad headaches _____	Colitis _____
Kidney disease _____	Pneumonia _____	Psoriasis _____	Anemia _____

Other significant illness (please list): _____

MEDICATIONS:

List any medications that you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

Name of Drug	Dose (Include strength, and number of pills per day)	How long have you taken this medication?	Please check: Did it help? A Lot	Some	Not at All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					

DRUG ALLERGIES AND SIDE EFFECTS: ☐ YES ☐ NO

Name of Drug	Describe reaction or side effect
1.	
2.	
3.	
4.	
5.	
6.	

PREVIOUS OPERATIONS:

Including cataracts, cosemetic, etc.

Type	Year	Surgeon	City
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ☐ Yes ☐ No Describe _____

Any other serious injuries? ☐ Yes ☐ No Describe _____

SOCIAL HISTORY:

☐ Never Married ☐ Married ☐ Divorced ☐ Separated

Spouse: ☐ Alive/Age _____ ☐ Deceased/Age _____ ☐ Major Illness: _____

Number of people in household: _____

Your occupation: _____ Hours worked per week: _____

EDUCATION: (circle highest level completed)

Grade School Junior High 7 8 9 College 1 2 3 4

High School 10 11 12 Post Graduate School 1 2 3 4

RHEUMATOLOGIC (ARTHRITIS) HISTORY:

At any time have you or a blood relative had any of the following?

Yourself (check if "yes")	Blood Relative (Relationship)		Yourself (check if "yes")	Blood Relative (Relationship)	
_____	_____	Arthritis (type unknown)	_____	_____	Lupus or "SLE"
_____	_____	Osteoarthritis	_____	_____	Ankylosing spondylitis
_____	_____	Rheumatoid Arthritis	_____	_____	Childhood arthritis
_____	_____	Gout	_____	_____	Osteoporosis

Other arthritis conditions: _____

Would you like a copy of your evaluation sent to a physician? ☐ Yes ☐ No

Name _____

Address _____

OFFICE USE ONLY

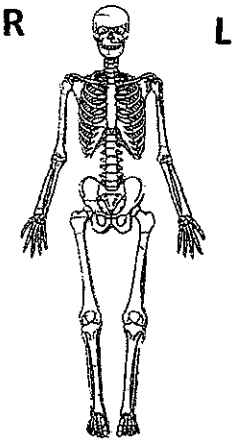
Impression: _____ **Plan:** _____

Considerations: _____

☐ **Handouts:** Medications: ___NSAID___MTX___Steriods___Plaq___Azulfidine___Imuran___Antidepressants
Disorders: ___DJD___RA___SLE___PMR / TA___Fibromyalgia___Raynaud's___Osteoporosis
Exercises: ___Shoulder Imp___Cuff___Fz Shoulder___Hip___Elbow___Back___Flex___Ext___Walking
Other: _____

☐ **Medicines:**

Add	Delete



☐ **Inj. Meds:** _____

☐ **Immunizations / TB Test:** _____

☐ **OT / PT:** _____

☐ **Nerve Test:** Diagnosis:_____ BUE RUE LUE ☐
Diagnosis:_____ BLE RLE LLE

☐ **Lab:** MTX, Immuran, Arava, Plaq, Remi, UA, ANA, CBC, CCP, QCRP, RA, SPEP, TFT, Anak, Azulf, Enbrel, NSAID, TCN, CYT, ESR ☐

☐ **X-rays:** Bone Scan, CXR, Ribs, C-Spine, L/R Sh, L/R Hum, L/R Elb, L/R Forearm, L/R Hand, L/R Wrist, Thoracic, L/S Spine, L/R Hip, ☐
L/R Femur, L/R Knee, L/R Tib/Fib, L/R Ankle, L/R Foot

☐ **MRI:** Today ☐

☐ **DEXA:** Dx: OP (1yr) / Steroids (1yr) / Osteomeds (2yr) / Post-menopausal (2yr) Today ☐

☐ **DRX:** _____ ☐

☐ **Matrix:** Today and / or x_____days ☐

☐ **Remicade Approval** ☐ **Orencia Approval** ☐ **Rituxan Approval** ☐ ☐

☐ **Synvisc / Hyalgan Approval:** _____ ☐

☐ **Chart Check in** _____ **for** _____ ☐

Notes:

Follow up with Dr. B or Jan_____ d / w / m for:_____