

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

ETHNICITY _____ 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 INSURANCE 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

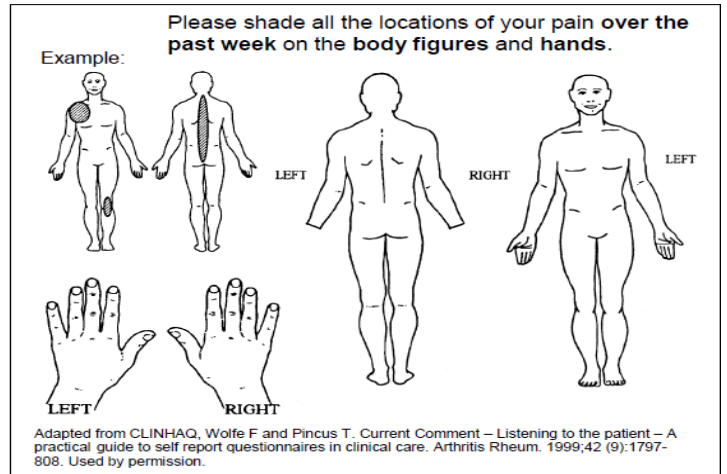
Primary reason for your visit today?

Describe briefly your present symptoms:

Date symptoms began (approximate): _____

Diagnosis: _____

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



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 | Crohns disease/ulcersative colitis |
| High cholesterol | Liver disease | Diabetes | Kidney disease |
| Heart attack or heart failure | Stomach ulcers | Thyroid problem | H.Pylori infection |
| Stroke | FRACTURES | Cancer | cataracts |
| | | Tuberculosis | Psoriasis |

Have you had any of these symptoms

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

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

Pain medications

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

Oral immunosuppressants (ie, pills)

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

Injectable or infusion immunosuppressants

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

Gout medication

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

Osteoporosis medication

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

Fibromyalgia or chronic pain medications

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