MISSISSIPPI RHEUMATOLOGY AND OSTEOPOROIS CLINIC, PLLC
SHARON HONG, M.D.
TERESA CROUT, M.D.
2550 FLOWOOD DRIVE, SUITE 300
FLOWOOD, MS 39232
PHONE: 601-420-0034 FAX:601-420-5482

Patient Name:

New Patient Appointment:

PLEASE FILL OUT THE ATTACHED PAPERS COMPLETELY AND BRING THEM TO YOUR APPOINTMENT

We want to take this opportunity to welcome you to our clinic. We are privileged you have chosen our clinic for your health care needs. Our staff is dedicated to the care of our patients and to make each visit as pleasant as possible. Your feedback is important to us. If at any time you experience a problem, please talk with our office manager. Only through communication with our patients can we improve our quality of care. We are pleased that you have chosen to place your trust in us and hope that you are satisfied with the care provided.

Our physicians participate in a number of contractual agreements with insurance companies. Our providers are participants with the Medicare program. We will file your insurance claim for you; however, you are responsible for knowing the terms of your contract with your insurance company. If your insurance company has special requirements for diagnostic testing it is important that you notify us in advance. With most insurance companies, a portion of fees will ultimately be paid by the patient. This may be in the form of a copay, a coinsurance percentage of the fees allowed, and/or deductible. We prefer that you take care of your part of the fees at the time the service is rendered. If you have any questions regarding your particular insurance coverage please call our office prior to your appointment. We will be happy to assist you. We feel that it is important that our patients understand that the responsibility for any remaining balance remains ultimately with the patient.

Please notify our staff of changes to address, telephone numbers, marital status, insurance coverage, etc., which may have occurred since your last visit. Accounts over 120 days will be referred to a collection agency. If you have questions concerning your bill, please call our office.

APPOINTMENTS AND CANCELLATIONS

Patients are seen by appointments only. If you need to cancel or reschedule your appointment, please call us during our office hours at least 48 hours in advance. If you arrive late for your appointment, your appointment time cannot be extended. If we cannot work you in, we will be happy to reschedule your appointment. If for some reason you are unable to keep this appointment, please be aware there is a $100.00 **NO SHOW** fee for not canceling or rescheduling 24-48 hours in advance. We will be happy to reschedule your appointment for a more convenient time.

PRESCRIPTIONS AND REFILLS

Prescriptions will only be refilled at the time of your appointment. Please make sure you bring all of your prescriptions with you to every visit to make sure you have adequate refills to last until your next office visit. **We DO NOT PRESCRIBE ANY NARCOTICS.**

ADDITIONAL FEES

A nominal fee may be charged for each form that various insurance carries, state departments or employers require the physician to fill out. A $1 per page charge will be assessed for copying your medical records for you. This is not covered by insurance and will be your responsibility at the time you receive them.

CONFIDENTIALITY

Mississippi Rheumatology and Osteoporosis Clinic, PLLC adheres to HIPAA (Health Insurance Portability and Accountability Act of 1996).

Please sign and date below stating that you have read the above.

SIGNATURE:_____ DATE:_____

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Sharon Hong, M.D.

Teresa Crout, M.D.

Office Hours: 8:00-4:30pm Monday-Thursday

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:_____ SSN:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____ Race:_____

Email Address:_____ Pharmacy:_____

Employer:_____ Retired?_____ Disabled?_____

Is this a work related injury?_____

Spouse Name:_____ Date of Birth:_____ SSN:_____

Spouse Employer:_____ Work #:_____

RESPONSIBLE PARTY (If different from above, please complete)

Guarantor's Name:_____ SSN:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Retired?_____ Disabled?_____

EMERGENCY CONTACT (other than spouse)

Name:_____ Relation to you:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

PRIMARY CARE PHYSICIAN

Name:_____ Office Phone:_____

PHYSICIAN WHO REFERRED YOU TO US:

Name:_____ Office Phone:_____

Address:_____

INSURANCE INFORMATION—PLEASE GIVE RECEPTIONIST YOUR CARD AT FIRST VISIT

Primary Insurance Company:_____

Address:_____

Insured Name:_____ Relationship:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

Secondary Insurance Company:_____

Address:_____

Insured Name:_____ Relationship:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

BENEFITS AUTHORIZATION:

I authorize treatment of the patient named above and agree to pay all fees and charges. I request that payment of authorized Medicare or other third-party insurances be made to Sharon Hong, M.D. or Teresa Crout, M.D. If assignment is accepted, I agree to pay any deductible, copay or disallowed charges. If assignment is not accepted, I agree to pay the entire amount due. I authorize any holder of medical information to release to any agents or their physical agent or any third-party insurance any information needed to determine these benefits. (A copy if this assignment is as valid as the original.)

Patient or Guarantor Signature:_____ Date:_____

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2550 FLOWOOD DRIVE, SUITE 300
FLOWOOD MS, 39232
(601) 420-0034

TO OUR PATIENTS:

We thank you for the trust you have placed in us for your health care needs. We are acutely aware of the escalating costs of medical care and insurance and make every attempt to maintain fees which are fair and reasonable considering the professional services rendered. We believe communication concerning our fees is critical, and in that direction, we have established the following financial policies for our clinic:

- For all patients covered by an insurance plan for which we are participating providers, we will accept benefits of assignment and file your claim. You will be responsible for your deductible and co-pay at the time services are rendered. We will make every effort to confirm that you have insurance coverage. However, the amount of benefits provided for your treatment may vary with each insurance plan. If you are unsure of the exact benefit paid by your plan (ex. Do I have a co-pay and if so how much?, Have I met my deductible?, etc.), then you should contact your insurance company for details.
- For other patients, payment in full is due at the time services are rendered.
- Accounts of 45 days old are considered delinquent. **Please follow up with your insurance company to ensure timely reimbursement.**
- I further agree that should the account become delinquent and require collection efforts, I will pay the cost of collections, including reasonable attorney's fees and collection agency fees.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES DESCRIBED ABOVE AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF MEDICAL SERVICES RENDERED ON MY BEHALF OR THOSE PERSONS FOR WHOM I AM RESPONSIBLE.

PATIENT OR GUARANTOR SIGNATURE:_____ DATE:_____

PRINT NAME:_____

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I hereby give my permission for Mississippi Rheumatology and Osteoporosis Clinic to provide medical care, including medication and treatment. I give my consent to have medical evaluations including, but not limited to x-ray, lab, injections, EKG, infusions, diagnostic procedures, or tests recommended by Mississippi Rheumatology and Osteoporosis Clinic. I understand that in medical emergency, I give my consent for Mississippi Rheumatology and Osteoporosis Treatment and Research Center to provide emergency medical treatment including, but not limited to hospitalization.

I hereby authorize the release of any requested medical information from private physicians and or institutions.

I understand I am assured of notification of any major medical treatment and side effects to any medication prescribed, to which I hereby consented.

Patient Signature	Date	Witness Signature

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CALL AGREEMENT

As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at that number.

_____ _____

PATIENT NAME DATE

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Mississippi Rheumatology and Osteoporosis Clinic's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

CONSENT TO ACCESS PATIENT'S MEDICAL RECORD

I, _____, give consent for Mississippi Rheumatology and Osteoporosis Center, PLLC to release any and all medical record information to _____.

_____ _____

Signature of Patient Date

MISSISSIPPI RHEUMATOLOGY AND OSTEOPOROSIS CLINIC, PLLC

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this Privacy Policy please contact Freda Jenkins of Mississippi Rheumatology and Osteoporosis Clinic, PLLC at (601) 420-0034.

I. **COMMITMENT TO PROTECTING PHI.** Mississippi Rheumatology and Osteoporosis Clinic, PLLC (the "Practice") is committed to protecting medical information about you and your health, including all demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care service ("protected health information" or "PHI"). This Policy describes how the Practice may use and disclose your rights to access and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Policy also describes your rights to access and certain obligations we have regarding the use and disclosure of your PHI. This Policy is in compliance with the requirements set forth under the health Insurance Portability and Accountability Act ("HIPAA") and those requirements as set forth by the secretary of the Department of Health and Human Services (the "Secretary"), as may be modified or adopted from time to time.

II. **USES AND DISCLOSURES.**

A. **Treatment, Payment and Health Care Operations.** The Practice may use and disclose PHI for the following purposes:

a. Treatment: To provide, coordinate, or manage your health care and related services, such as disclosing PHI to other healthcare professionals involved in your care. For example, phoning in prescriptions to your pharmacy or scheduling lab work.

b. Payment: To bill and collect payment from you, an insurance company or third party. For example, to obtain prior approval of a particular treatment, or to substantiate services rendered for payment purposes.

c. Health Care Operations: To ensure that you receive quality care. For example, to evaluate the performance of our staff in caring for you, to help us decide what additional services we should offer, or whether certain new treatments are effective.

d. Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at this office.

e. Treatment Alternatives and Health-Related Products and Services: The Practice may recommend possible treatment alternatives or other health-related benefits and series that may be of interest to you. For example, to send you a brochure about products or services that may be beneficial to you.

B. **Special Situations.** Subject to all applicable legal requirements and limitations, the Practice may use or disclose PHI without your permission for the following purposes:

a. Required By Law: The Practice will Disclose PHI about you when required to do so by federal, state or local law.

b. Public Health: The Practice may disclose PHI about you for public health activities, including disclosures:

i. to prevent or control disease, injury or disability;

ii. to report births and deaths;

iii. to report child abuse or neglect;

iv. to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities raised to the quality, safety, or effectiveness of FDA-regulated products of services and to report reactions to medications or problems with products;

v. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

vi. to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. (The Practice will only make this disclosure if the patient agrees or when required or authorized by law.)

c. Victims of Abuse, Neglect or Domestic Violence: The Practice may disclose PHI about you to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic if we reasonably believe you to be a victim of abuse, neglect, or domestic violence to the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law, you agree to the disclosure; or to the extent the disclosure is expressly authorized by statute or regulation.

d. Health Oversight: The Practice may disclose PHI to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws or other legal or regulatory requirements.

e. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the Practice may disclose PHI in response to a court or administrative order. Subject to all applicable legal requirements, the Practice may also disclose PHI in response to a subpoena or other legal process.

f. Law Enforcement: The Practice may release PHI if asked to do so by a law enforcement official:
   i. in response to a court order, subpoena, warrant, summons or similar process;
   ii. to identify or locate a suspect, fugitive, material witness or missing person;
   iii. about the victim of a crime under certain limited circumstances;
   iv. about a death we believe may be the result of criminal conduct;
   v. in emergency circumstances, to report a crime, the location thereof the victims, or the identity, description or location of the perpetrator.

g. Coroners, Medical Examiners and Funeral Directors: The Practice may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Practice may release information to a Funeral Director, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

h. Organ and Tissue Donation: If you are an organ donor, the Practice may release PHI to organizations that handle organ procurement of organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

i. Research: The Practice may use and disclose PHI for research projects that are subject to a special approval process and the requirements of applicable law.

j. To Avert a Serious Threat to Health or Safety: Subject to applicable law, the Practice may use and disclose PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. The Practice may also use and disclose PHI if necessary for law enforcement authorities to identify or apprehend and individual.

k. Specialized Governmental Functions: In certain circumstances the Practice may be required to disclose PHI to authorized governmental agencies for national security activities or for protective services for the President or other authorized persons. If you are a member of the Armed Forces, we may release PHI as required by military command authorities. We may also release PHI about foreign military authority.

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FROM I-55: Get onto Lakeland Dr. and go toward Flowood (away from St. Dominic). Continue down Lakeland and look for the intersection of River Oaks Dr. At this red light you will turn right by Magnolia Bank. Pass River Oaks Hospital on the left. At the first red light take a left. We are the 3rd building on the right.

FROM HWY 49 (FLORENCE, RICHLAND, HATTIESBURG, ETC): Get on Hwy 49 going North. After you go through Richland, you will go under I-20 and continue on toward Flowood. The road will go from a 4-lane to a 2-lane. Go straight until the next red light. At this light there will be a Texaco on your right and River Oaks Hospital on your diagonal left. Go through the red light and we are the 3rd building on the right.

FROM I-20 WEST: Get off at the Flowood exit and take Hwy 49 North. Follow Hwy 49 North until it turns into a 2-lane. At the next red light, you will see a Texaco on the right and River Oaks Hospital on your diagonal left. Go through the red light and we are the 3rd building on the right.

FROM I-20 EAST: Get off at the Flowood exit and stay to the right. Follow Hwy 49 North until it turns into a 2-lane. At the next red light, you will see a Texaco on the right and River Oaks Hospital on your diagonal left. Go through the red light and we are the 3rd building on the right.

FROM PEARL/BRANDON: Get onto Airport Road going toward Lakeland Drive. At the first red light (intersection of Flowood Drive), turn left. After the red light on Flowood Drive we are the 1st building on the left.

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home: (____) _____ Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

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

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

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

_____

_____

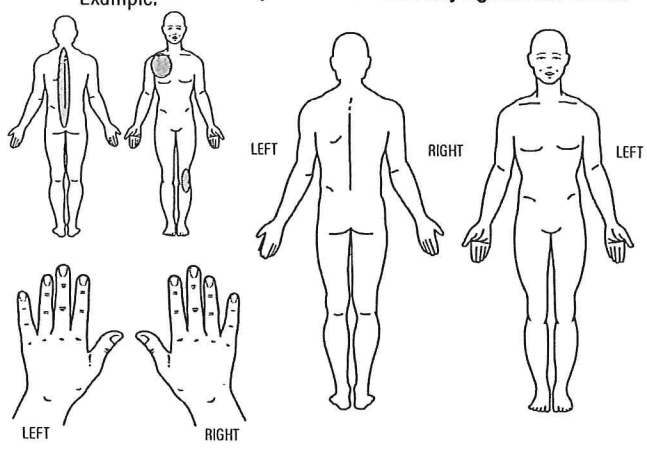
_____

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

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands.**



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.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Physician Initials: _____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ____/____/____ Date of last eye exam: ____/____/____ Date of last chest x-ray: ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

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

Genitourinary

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

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____

Date of last pap? ____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness

  Lasting how long?

  _____Minutes _____Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

  List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name: _____ Date: _____ Physician Initials: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No

If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

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

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes *Describe:* _____

Any other serious injuries? ❑ No ❑ Yes *Describe:* _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number decreased _____

Number of siblings _____ Number living _____ Number decreased _____ List ages of each _____

Health of children _____

_____

Do you know any blood relative who has or had: ***(check and give relationship)***

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name: _____ Date: _____ Physician Initials: _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: *Helped?*		
			A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: 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 spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name: _____ Date: _____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list:

Patient's Name: _____ Date: _____ Physician Initials: _____

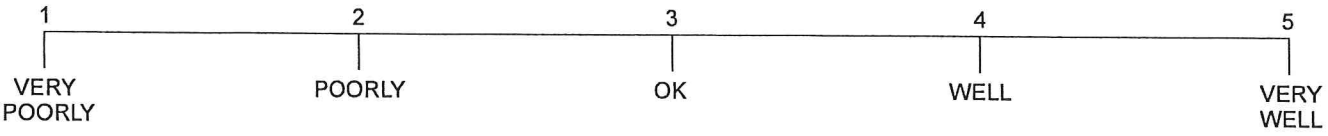
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

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

What is the hardest thing for you to do? _____

Are you receiving disability?	Yes ❑	No ❑
Are you applying for disability?	Yes ❑	No ❑
Do you have a medically related lawsuit pending?	Yes ❑	No ❑

Patient's Name: _____ Date: _____ Physician Initials: _____