ARTHRITIS ASSOCIATES PA

New patient history form Dictated___

Name: _____ **Record #:** _____ **Age:** ____ **Date:** _____

Address: _____ Phone number: _____

Referring provider's name and address: _____

_____

Primary care physician: _____

CURRENT SYMPTOMS

What questions do you want your doctor to answer? _____

_____

Are you having any pain? _____ If so, please describe your pain:

Location: Where is your pain? _____

Does your pain spread to any other part of your body? ____ If so, where? _____

Severity: (circle) Mild Moderate Severe

Please rate your pain on this scale:

0 _____ 10

No pain Unbearable pain

Blood Pressure: _____

Pulse: _____

Respiratory: _____

Temperature: _____

Height: _____

Weight: _____

Quality: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Tingling ☐ Throbbing ☐ Stabbing

Timing: When do you have the pain (morning, midday, evening, night, constantly)? _____

How long does your pain last or has it lasted (minutes, hours, days, weeks, months)? _____

Context: In what situations do you have the pain (rest, exercise, stress)? _____

Mitigating factors: What makes your pain worse? _____

What makes it better? _____

Associations: Do you have any symptoms associated with your pain? _____ If so, what are they? _____

Do you have any stiffness? ____ If so, when do you notice it most? _____

How long does your stiffness last when it occurs? _____

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

NAME OF PROCEDURE	DATE	√ IF DONE HERE IN THIS OFFICE	PRINT NAME OF FACILITY IF PROCEDURE DONE ELSEWHERE
DATE OF LAST LABS DRAWN	_____	____	_____
DATE OF LAST DEXA / BONE DENSITY SCAN	_____	____	_____
DATE OF LAST PPD / TUBERCULOSIS SKIN TEST	_____	____	_____
DATE OF LAST FLU / INFLUENZA IMMUNIZATION	_____	____	_____
DATE OF LAST PNEUMONIA IMMUNIZATION	_____	____	_____
DATE OF LAST TETANUS IMMUNIZATION	_____	____	_____

ALLERGIES (TO MEDICATIONS OR OTHERS YOUR DOCTOR SHOULD KNOW): _____

*******PLEASE SEE OTHER SIDE OF THIS SHEET TO LIST CURRENT MEDICATIONS*******

LIST OF ALL MEDICATIONS

PRESCRIPTIONS	DOSAGE	FREQUENCY	ROUTE	DATE STARTED
OVER THE COUNTER				
HERBALS				
VITAMINS				
MINERAL				
DIETARY				

PATIENT NAME: _____

Please review the list of symptoms below

Fill in the "Yes" bubble if you suffer from the symptoms or have any of the health issues listed. Fill in the "No" bubble if you do not.
*PLEASE FILL IN EACH BUBBLE COMPLETELY *DO NOT HAVE TO COMPLETE IF FILLED OUT ON-LINE PRE-ASSESSMENT

CONSTITUTIONAL	YES	NO
Unexplained weight loss	O	O
Unexplained weight gain	O	O
Fever	O	O
Chills	O	O
Fatigue	O	O

EYES	YES	NO
Cataract	O	O
Change in vision	O	O
Red eye	O	O
Glasses	O	O
Dry eye	O	O

ENMT	YES	NO
Bleeding from gums	O	O
Problems hearing	O	O
Change in your voice	O	O
Denture	O	O
Hoarse voice	O	O
Sinus problems	O	O
Ringing in the ears	O	O
Mouth or nose ulcers	O	O
Dry mouth	O	O

CARDIOVASCULAR	YES	NO
Angina	O	O
Heart problems	O	O
Chest pain	O	O
Leg pain with walking	O	O
Swelling in the legs	O	O

SKIN	YES	NO
Skin changes	O	O
Lesions	O	O
Itching	O	O
Rashes	O	O
Dry skin	O	O
Sensitivity to sunlight	O	O

GASTROINTESTINAL	YES	NO
Blood in stool	O	O
Change in bowel habits	O	O
Constipation	O	O
Diarrhea	O	O
Difficulty swallowing	O	O
Heartburn	O	O
Nausea or vomiting	O	O
Black tarry stool	O	O
Stomach ulcers	O	O

GENITOURINARY	YES	NO
Difficulty urinating	O	O
Blood in urine	O	O
Urinary urgency	O	O
Incontinence	O	O
Urination at night	O	O

HEMATOLOGY/ONCOLOGY		
Anemia or low blood	O	O
Easy bruising	O	O
Swollen lymph nodes	O	O
Cancers	O	O

RESPIRATORY	YES	NO
Bronchitis	O	O
Cough	O	O
Coughing up blood	O	O
Shortness of breath	O	O
Wheezing	O	O
Heavy snoring	O	O
Fatigue after sleeping	O	O

ENDOCRINE	YES	NO
Problems with heat	O	O
Problems with cold	O	O
Swelling in neck	O	O
Frequent urination	O	O
Excessive thirst	O	O
Changes in hair	O	O

MUSCULOSKELETAL	YES	NO
Neck Pain	O	O
Gout	O	O
Injury to limbs	O	O
Joint pain	O	O
Joint stiffness	O	O
Locking joints	O	O
Back Pain	O	O
Swollen joints	O	O
Change in finger color with exposure to cold	O	O

PSYCHIATRIC	YES	NO
Depression or sadness	O	O
Feel like hurting someone	O	O
Feel like hurting yourself	O	O
Problems concentrating	O	O
Anxiety	O	O
Difficulty sleeping	O	O
Problems staying asleep	O	O

NEUROLOGIC	YES	NO
Change in memory	O	O
Dizziness	O	O
Headache	O	O
Imbalance	O	O
Tingling/Numbness	O	O
Weakness	O	O
Tremor	O	O
Seizures	O	O

FAMILY HISTORY

Does anyone in your family have arthritis? _____ If so, who and what kind? _____

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		☐ Alive ☐ Deceased		
Mother		☐ Alive ☐ Deceased		
1. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
2. ☐ Brother ☐ Sister		☐ Alive ☐ Deceased		
3. Other: _____		☐ Alive ☐ Deceased		

DISEASE			RELATIVE	DISEASE			RELATIVE
Lupus	☐ Yes	☐ No	_____	Iron Storage Disease	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____	High Blood Pressure	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____	High Cholesterol	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____	Thyroid Disease	☐ Yes	☐ No	_____
Depression, Suicide	☐ Yes	☐ No	_____	Cancer	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____	What type? _____			
Macular degeneration	☐ Yes	☐ No	_____	Other: _____			

PERSONAL & SOCIAL HISTORY

Do you use cigarettes, pipes, cigars or chew tobacco? ☐ Yes ☐ No

How much do you smoke? _____

For how long have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No

How much per week? _____

Do you use illegal drugs or abuse prescription medications? ☐ Yes ☐ No

Do you drink coffee, sodas or other caffeinated beverages? ☐ Yes ☐ No

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other: _____

Occupation: _____ Do you have an Advance Directive? ☐ Yes ☐ No

Any history of tick bites or tick exposure? _____ If so, in what state/region? _____

OVERALL ASSESSMENT

Considering all the ways that illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well |——————————————————————————| Very Poorly

PATIENT NAME: _____

Because of recent changes to Medicare guidelines, all physicians must now obtain information to document quality of care or face a penalty. Please complete the following to help us comply with the new regulations.

1. Do you use tobacco products ?	YES	NO
2. Have you fallen or almost fallen in the past year?	YES	NO
3. Have you ever had Pneumococcal vaccination?	YES	NO
4. Have you had the influenza vaccine this flu season?	YES	NO

5. Depression screening:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

6. Functional status (MD-HAQ):

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank-you.

1. Please check (✓) the ONE best answer for your abilities at this time:

AT THIS MOMENT, are you able to,	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including 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 ground?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
e. Wash and dry your entire body?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
f. Bend down and pick up clothing from the floor?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
g. Turn faucets on and off?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
h. Get in and out of a car, bus, train, or airplane?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
i. Walk two miles?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
j. Participate in sports and games as you would like?	☐ (0)	☐ (1)	☐ (2)	☐ (3)
k. Get a good night's sleep?	☐ (0)	☐ (1.1)	☐ (2.2)	☐ (3.3)
l. Deal with feelings of anxiety or being nervous?	☐ (0)	☐ (1.1)	☐ (2.2)	☐ (3.3)
m. Deal with feelings of depression or feeling blue?	☐ (0)	☐ (1.1)	☐ (2.2)	☐ (3.3)

For office use only

FN ☐

1=0.33 16=5.33
2=0.67 17=5.67
3=1.00 18=6.00
4=1.33 19=6.33
5=1.67 20=6.67
6=2.00 21=7.00
7=2.33 22=7.33
8=2.67 23=7.67
9=3.00 24=8.00
10=3.33 25=8.33
11=3.67 26=8.67
12=4.00 27=9.00
13=4.33 28=9.33
14=4.67 29=9.67
15=5.00 30=10.0

PS ☐

PN ☐

AM ☐

FT ☐

CH ☐

GL ☐

2. How much PAIN have you had because of your illness in the PAST WEEK? Place a mark on the line below to indicate how severe your pain has been:

NO PAIN ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ PAIN AS BAD AS IT COULD BE
0 1 2 3 4 5 6 7 8 9 10

3. When you get up in the morning do you feel stiff? ☐ YES ☐ NO

If you answer NO please go to item number 4.
If you answer YES, please write the number of minutes:_____, OR number of hours:_____
until you are as limber as you will be for the day?

4. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Place a mark on the line below

FATIGUE IS NO PROBLEM ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ FATIGUE IS A MAJOR PROBLEM
0 1 2 3 4 5 6 7 8 9 10

5. How do you feel today compared to TWO WEEKS AGO? Please check only one:

☐ MUCH BETTER(1) ☐ BETTER(2) ☐ THE SAME(3) ☐ WORSE(4) ☐ MUCH WORSE(5)

6. Considering all the ways in which illness and health conditions may affect you at this time, please make a mark on the line below to show how you are doing:

VERY WELL ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ VERY POORLY
0 1 2 3 4 5 6 7 8 9 10

PATIENT INFORMATION

Patient Name:_____ **D.O.B.:**_____ **S.S.#:**_____

Street or P.O. Box_____ **City**_____ **ST**_____ **Zip**_____

Sex: Female/Male **Marital Status: Single Married Divorced Widowed**

Home Phone:_____ **Work Phone:**_____ **ext:**_____ **Cell:**_____

Employer:_____ **Address:**_____

Responsible Party:_____ **Relationship:**_____ **Ph.#:**_____

Emergency Contact:_____ **Relationship:**_____ **Ph#:**_____

****Referring Doctor:**_____

INSURANCE INFORMATION
MUST LIST ALL INSURANCE POLICIES

Primary Insurance:_____

ID:_____ **Group#:**_____ **Policy**_____ **Effective Date:**_____

Insurance Address:_____ **Phone #:**_____

Policy Holder's Name:_____ **D.O.B.:**_____

Insured Party S.S.#:_____ **Patient's relationship to Policy Holder:**_____

Secondary Insurance:_____

ID:_____ **Group#:**_____ **Policy**_____ **Effective Date:**_____

Insurance Address:_____ **Phone#:**_____

Policy Holder's Name:_____ **D.O.B.:**_____

Insured Party S.S.#:_____ **Patient's relationship to Policy Holder:**_____

Third Insurance:_____

ID:_____ **Group#:**_____ **Policy**_____ **Effective Date:**_____

Insurance Address:_____ **Phone #:**_____

Policy Holder's Name:_____ **D.O.B.:**_____

Insured Party S.S.#:_____ **Patient's relationship to Policy Holder:**_____

I authorize the release of my medical information to my insurance carrier(s) if requested.

I authorize my insurance(s) to pay medical benefits to Arthritis Associates, P.A.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENTS OF BENEFITS
WE WILL NOT BE ABLE TO FILE INSURANCE CLAIMS IF THIS AUTHORIZATION IS NOT SIGNED

Signature of Patient or Responsible Party:_____ **Date:**_____

FOR OUR MEDICARE PATIENT'S ONLY

MEDICARE GUIDELINES REQUIRE THAT WE DETERMINE WHICH OF YOUR INSURANCE CARRIERS MUST BE FILED AS THE PRIMARY PAYOR. PLEASE ASSIST US IN FILING YOUR MEDICAL CLAIMS AS ACCURATELY AS POSSIBLE BY COMPLETING THE REQUESTED INFORMATION.

THANK YOU!

PATIENT'S MEDICARE #:_____ **EFFECTIVE DATE:**_____

1.) ***IS THE PATIENT ELIGIBLE FOR MEDICARE DUE TO:***
OVER 65 YEARS OLD DISABILITY END STAGE RENAL DISEASE TRANSPLANT
****IF TRANSPLANT, PLEASE LIST THE DATE OF TRANSPLANT:**_____

2.) ***IS THE PATIENT CURRENTLY EMPLOYED OR ON TEMPORARY LEAVE OF ABSENCE?***
YES NO

3.) ***IF EMPLOYED, IS THE PATIENT COVERED BY MEDICAL INSURANCE THROUGH ACTIVE EMPLOYMENT?*** **YES NO**

4.) ***IF THE PATIENT HAS INSURANCE THROUGH CURRENT EMPLOYER, HOW MANY EMPLOYEES ARE IN THE GROUP?***
MORE THAN 100 EMPLOYEES LESS THAN 100 EMPLOYEES LESS THAN 20 EMPLOYEES

5.) ***IS THE PATIENT'S SPOUSE CURRENTLY EMPLOYED?*** **YES NO**

6.) ***IF THE PATIENT'S SPOUSE IS CURRENTLY EMPLOYED, IS THE PATIENT COVERED BY A GROUP INSURANCE THROUGH THE CURRENT EMPLOYER GROUP?*** **YES NO**

7.) ***IF THE PATIENT HAS COVERAGE THROUGH THEIR SPOUSE'S ACTIVE EMPLOYER GROUP, HOW MANY EMPLOYEES ARE IN THE GROUP?***
MORE THAN 100 EMPLOYEES LESS THAN 100 EMPLOYEES LESS THAN 20 EMPLOYEES

8.) ***IS YOUR COVERAGE THORUGH AN EMPLOYER GROUP COBRA PLAN?*** **YES NO**
(ARE YOU PAYING PREMIUMS?)

9.) ***ARE YOU BEING SEEN FOR ANY MEDICAL PROBLEM THAT COULD BE COVERED BY…***

WORKER'S COMPENSATION	**YES**	**NO**
MOTOR VEHICLE/LIABILITY INSURANCE	**YES**	**NO**
BLACK LUNG PROGRAM	**YES**	**NO**

FOR BUSINESS OFFICE USE ONLY:

RECEIVED BY (INITIAL):_____ **DATE:**_____