Rheumatic Disease Center
Patient History Form

Account #:_____ Appointment Date:_____ RDC Provider:_____

Name: _____
Last First Middle Inital

Birth Date: ___/___/___ **Sex:** __F __M **SS#**_____ - _____ - _____
mo day year

Address: _____
Street Apt.# City State Zip

Home Phone: (__) _____ Cell: (__) _____ Work: (__) _____

OKAY TO LEAVE MESSAGE AT HOME: *Y N* EMAIL: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Referred by: (check one) ___ Self ___ Family ___ Friend ___ Physician/Health Professional

Name of Person Making referral: _____

Occupation: _____ Employer's Name: _____
# of hour per week

Emergency contact: _____ Relationship: _____ Phone: _____

The government is requiring us to collect the following data:
Ethnicity: _____ American Indian or Alaskan Native _____ Black or African American _____ Native Hawaiian
_____ Asian _____ White _____ Other _____ refuse to report

Race: _____ Hispanic _____ Non Hispanic _____ refuse to report

Education (circle highest level attended): Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School_____

Describe briefly your present symptoms: _____
_____
_____
_____

Date symptoms began (approximate)_____ Are you Right Handed_____ or Left Handed_____

Indicate below any previous treatment for this problem: (medications to be listed later):
Physical Therapy: _____
Injections: _____
Surgery: _____
Hospitalizations: _____
Other Physicians involved in your care: _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY
At any time have you or a blood relative had any of the following? (Check if "yes")

	YOURSELF	RELATIVE/Relationship
Arthritis		
Osteoarthritis		
Gout		
Childhood Arthritis		
Lupus or "SLE"		

	YOURSELF	RELATIVE/Relationship
Rheumatoid Arthritis		
Ankylosing Spondylitis		
Osteoporosis		
Psoriasis		
Other arthritis conditions:		

SOCIAL HISTORY

Marital Status: ____ single ____ married ____ widowed ____ divorced ____ separated ____ domestic partner

Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes how many cups/glasses per day?_____
Do you drink alcohol? ☐ Yes ☐ No
Number per week _____
Do you use street/recreational drugs? ☐ Yes ☐ No
If yes please list: _____
Do you get enough sleep at night? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
☐ In the Past -- Quit Date?_____
Do you exercise regularly? ☐ Yes ☐ No
Type of exercise_____
Number of times per week _____ Length of time ____
Hobbies _____
Do you wake up feeling rested? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

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

☐ Heart Problems
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Stroke
☐ Tuberculosis
☐ Psoriasis
☐ Goiter/Thyroid disorder
☐ Cataracts
☐ Diabetes
☐ Glaucoma
☐ Colitis
☐ Jaundice/hepatitis
☐ Stomach ulcers
☐ Anemia
☐ Cancer
☐ HIV/AIDS
☐ Leukemia/Lymphoma
☐ Headaches/Migraines
☐ Epilepsy
☐ Visual Problems
☐ Sleep Apnea
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Kidney Disease
OTHER: _____
_____

PREVIOUS OPERATIONS:

TYPE	Year	Reason if known

Any previous fractures? ☐ No ☐ Yes Describe: _____
Any other serious injuries? ☐ No ☐ Yes Describe: _____

Any Hospitalizations -other than surgeries? ☐ No ☐ Yes Describe: _____

_____

_____

FAMILY HISTORY: **IF LIVING** | **IF DECEASED**

	AGE	HEALTH	AGE AT DEATH	CAUSE
Father				
Mother				

Number of siblings _____ Number Living _____ Number of deceased _____

Number of children _____ Number Living _____ Number of deceased _____

FAMILY HISTORY:

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

☐ Alcoholism_____ ☐ Colitis_____ ☐ Heart disease _____ ☐ Rheumatic Fever _____

☐ Asthma_____ ☐ Diabetes_____ ☐ Stroke_____ ☐ Hypertension _____

☐ Migraines_____ ☐ Epilepsy_____ ☐ Leukemia_____ ☐ Tuberculosis _____

☐ Cancer_____ ☐ Goiter _____ ☐ Psoriasis_____ ☐ Bleeding Tendency_____

PRESENT MEDICATIONS

Drug Allergies: ☐ No ☐ Yes To what?_____

_____

Type of Reaction: _____

PRESENT MEDICATIONS: (All medications currently taking) (See next page for rheumatology drug history)

NAME OF DRUG	DOSE (Include strength & number of pills per day)

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 reaction you may have had. Record your comments in the spaces provided.

		Please Check: HELPED?			
Drug Names/Dosage	**Length of time**	**A Lot**	**Some**	**Not at All**	**Reactions**
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)					

Circle any you have taken in the past

Ansaid (flurbiprofen) Arthrotec (diclofenac + Misoprpstil) Aspirin (including coated aspirin) Celebrex (celeboxib)
Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal)
Feldene (piroxicam) Indocin (Indomethacin) Lodine (etodolac) Meclomen (meclofenamate)
Mobic (Meloxicam) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (Naproxen)
Oruvail (Ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Voltaren (diclofenac)

Drug Names/Dosage	**Length of time**	**A Lot**	**Some**	**Not at All**	**Reactions**
Pain Relievers					
Acetaminophen (Tylenol)					
Codeine/Hydrocodone (Vicodin, Tylenol 3)					
Propoxyphene (Darvon/Darvocet)					
Tramadol (Ultram or Ultracet)					
Other:					
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)					
Arava (Leflunomide)					
Gold shots (Myochrysine or Solganol)					
Hydroxychloroquine (Plaquenil)					
Penicillamine (Cuprimine or Depen)					
Methotrexate (Rheumatrex)					
Azathioprine (Imuran)					
Sulfasalazine (Azulfidine)					
Quinacrine (Atabrine)					
Cellcept					
Cimzia					
Cyclophosphamide (Cytoxan)					
Cyclosporine A (sandimmune or Neoral)					
Etanercept (Enbrel)					
Infliximab (Remicade)					
Humira (Adalimunab)					
Kineret (Anakinra)					
Rituxan (Rituxinab)					
Orencia (Abatacept)					
Simponi					
Actemra					
Osteoporosis Medications					
Alendronate (Foxamax)					
Calcitonin Nasal Spray (miacalcin)					
Estrogen (Premarin etc)					
Ibandronate (Boniva)					
Raloxifene (Evista)					
Risedronate (Actonel)					
Teriparatide (Forteo)					
Zoledronic Acid (Reclast)					
Gout Medications					
Allopurinol (Zyloprim/Lopurin)					
Colchicine					
Probenecid (Benemid)					
Uloric					
Other:					
Others					
Breast Cancer Medication					
Glucosamine					
Cortisone/Prednisone					
Hyalgan/Synvisc/Euflexxa/Orthovisc/Supartz					
Herbal or Nutritional Supplements					

ACTIVITIES OF DAILY LIVING

I live in a (circle one): Home Town Home Apartment Assisted 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?_____

Rate your overall assessment (of how you function on a daily basis)
On the scales below, please circle a number which best describes your situation:

Very POORLY POORLY OK Well Very WELL

Rate your pain

No Pain 1 2 3 4 5 6 7 8 9 10 Most Severe Pain

After you wake up, how long does it take you to limber up? AM Stiffness:_____ in minutes

What joints are stiff? _____

Please try to answer all of the following questions, answer exactly as you think or feel.

There are no right or wrong answers. Check, the one best answer for each question.

AT THIS MOMENT, Are you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE**
Dress yourself, including tying shoelaces, doing buttons?				
Get out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on a flat ground?				
Wash and dry your entire body?				
Bend down to pick up clothing from the floor?				
Turn regular faucets on and off?				
Get in and out of a car, bus, train, and airplane?				
Walk two miles?				
Participate in sports and games as you like?				
Get a good night's sleep?				
Deal with feelings of anxiety or being nervous?				
Deal with feelings of depression or feeling blue?				

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

SYSTEMS REVIEW

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____/_____/_____

As you review the following list, please check any of those problems, which have significantly affected you.

Constitutional

- ❑ Night sweats
- ❑ Weight gain _____LB
- ❑ Loss of appetite
- ❑ Fever
- ❑ Weight loss _____LB
- ❑ Fatigue / Weakness

Eye

- ❑ Dry eye
- ❑ Red eyes
- ❑ Contacts
- ❑ Loss of vision
- ❑ Eye irritation or pain
- ❑ Eye mattering
- ❑ Blurring of vision

ENT

- ❑ Dry mouth
- ❑ Cold / Congestion
- ❑ Nosebleeds
- ❑ Hearing loss
- ❑ Mouth sores
- ❑ Sore throat
- ❑ Ringing in ears
- ❑ Sinus pain
- ❑ Nasal polyps
- ❑ Rhinitis/ conjunctivitis

Endocrinology

- ❑ New hormone pills
- ❑ New thyroid problems
- ❑ Excessive thirst
- ❑ Polyuria / frequent urinating
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Diabetes

Respiratory

- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Painful breathing / pleurisy
- ❑ Cough

Cardiovascular

- ❑ High blood pressure
- ❑ Raynaud's
- ❑ Dizziness
- ❑ Chest pain
- ❑ Palpitations
- ❑ Leg edema

Gastroenterology

- ❑ Nausea / Dyspepsia
- ❑ Heartburn
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Dysphagia
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool

Hematology / Lymph

- ❑ Anemia
- ❑ More infections than others
- ❑ Swollen glands

Musculoskeletal

- ❑ Back or neck pain
- ❑ Joint stiffness
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Leg cramps
- ❑ Bone density done elsewhere
- ❑ Fracture

Dermatology

- ❑ New hair loss
- ❑ New lumps / bumps
- ❑ Allergy to sun
- ❑ Color change in cold
- ❑ Rash
- ❑ Psoriasis
- ❑ Hives
- ❑ Easy bruising
- ❑ Skin cancer

Neurology

- ❑ Muscle cramps
- ❑ Muscle weakness
- ❑ New weakness of arm or leg
- ❑ New headache
- ❑ Tingling numbness hands or feet
- ❑ Seizures
- ❑ Memory loss
- ❑ Lightheaded / fainting
- ❑ Loss of balance / falls

Psychology

- ❑ Insomnia
- ❑ Feeling blue or depressed
- ❑ High stress level
- ❑ Difficulty with sleep
- ❑ Mental or physical abuse
- ❑ Worries or anxiety

Male Reproductive

- ❑ Risk for Sexually Transmitted Disease / HIV
- ❑ Impotence
- ❑ Penile discharge

Female Reproductive

- ❑ Vaginal discharge or bleeding
- ❑ Menstrual irregularity
- ❑ Risk of Sexually Transmitted Disease / HIV
- ❑ Contraception
- ❑ Menopause
- ❑ Hot Flashes

Urology

- ❑ Painful urinating
- ❑ Blood in urine
- ❑ Frequent urinating
- ❑ Loss of urinary control
- ❑ Kidney stone
- ❑ Urinating at night

Number of:

_____ Pregnancies

_____ Deliveries

_____ Miscarriages/abortions

RHEUMATIC DISEASE CENTER
7080 N. Port Washington Rd.
Glendale, WI 53217
(414) 351-4009
Fax (414) 351-7060

John A. Albert, MD
Steven R. Bergquist, MD
Miriam R. Cohen, MD
Suhail Hameed, MD
Jonathan K. Kushi, MD
Kurt R. Oelke, MD
Farrukh S. Pasha, MD
Jennifer Zastrow, PA-C

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FINANCIAL POLICY

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is supplied.

Our billing department will submit your charges directly to your insurance company. We require a copy of your insurance card, mailing address and payment of your deductible and/or co-pay at the time of service. Please keep us informed of any and all insurance changes. Since coverage is an agreement between you and your insurance company, you need to be aware of the benefits provided and see that reimbursement is made.

HMO/PPO or Contracted Insurance Coverage

If your insurance requires referral forms or prior authorization, the paperwork must be in our office at the time of your visit. It is the patient's responsibility to request that the proper forms are generated by his/her primary care physician. GENERALLY A HMO WILL NOT ALLOW US TO SEE YOU WITHOUT A PRIOR WRITTEN REFERRAL. In the event that prior authorization is not verifiable the day of your appointment, you will be asked to reschedule your appointment. Please keep your referrals current. If you are unsure when your referral expires, please contact your primary care physician.

MEDICARE

We accept assignment on all Medicare claims. Office visits are covered under part B of the Medicare program. Medicare pays 80% of their allowable charge after you pay your annual deductible. We will be happy to submit any remaining balance to your secondary insurance company, however, you will be responsible for any deductible and any portion of your 20% co-insurance not paid by your secondary insurance.

MEDICAID

If you have Medicaid coverage, we must have your current Medicaid card at the time of your visit. Payment of your co-pay is expected at the time of your visit.

LAB

Your physician may order lab tests that cannot be done in our office laboratory. These tests will be sent to an outside lab. A separate bill from the outside lab may be sent to you.

To avoid misunderstanding, we invite you to discuss financial problems, if possible, prior to services being rendered. If you have any questions or concerns, please feel free to contact our billing department or office manager weekdays between 9:00 am and 4:00 pm at (414) 351-4009.

I have read, understand, and agree to the terms of all the above information. I hereby assign payment of medical benefits directly to the Rheumatic Disease Center. I agree that non-covered medical services are my responsibility. A photocopy of the agreement shall be considered as effective and valid, as the original. I authorize the release of any medical information necessary to process my claims. This authorization is in effect until I choose to revoke it.

Name_____ Signature _____ Date _____
Please Print