RHEUMATIC
DISEASE
CENTER

Welcome to the Rheumatic Disease Center. We look forward to seeing you soon at one of our clinics.

7080 N Port Washington Rd
Glendale, WI 53217
(414) 351-4009

2500 W Layton Ave, Suite 280
Milwaukee, WI 53221
(414) 351-4009

We hope that the following information will be of help to you and assist us in your care:

Your first appointment will take approximately one hour. You may be here longer if the doctor orders x-rays and/or lab work.

Please come 15 minutes before your scheduled appointment time to check in. If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

It is important that you bring your driver's license or other photo ID and all of your insurance cards. We scan this information into our computer.

We collect co-pays at the time of service. For your convenience we accept Visa, Mastercard, Discover, personal check and cash.

If you do not give us 48 hours notice prior to canceling or you do not show up for your new patient appointment, the clinic may not be able to reschedule you appointment. The fee for a missed or late canceled appointment is $35.

Please bring a list of medications you are currently taking.

If you have had x-rays, EKG, MRI's, CT scans or lab work done, please bring the results with you.

If you have previously seen a rheumatologist, please bring those records with you or have them faxed to us at 414-351-7060.

Mail the completed medical information forms unless your appointment is less than five days from the date you complete this form, in which case please bring this information with you.

All phone calls, including appointments for our Layton clinic, all refill requests, and mailings are handled by our main office on Port Washington Road.

At your first visit you will receive a copy of our privacy policy. We look forward to seeing you!

Sincerely,

The Rheumatic Disease Center

John A. Albert, MD
Steven R. Bergquist, MD
Mary E. Cronin, MD
Suhail Hameed,MD
Jonathan K. Kushi, MD
Kurt R. Oelke, MD
Farrukh S. Pasha, MD
Jennifer Poedel, PA-C

Patient History Form

Appointment Date

RDC Provider

Name

First Name

Last Name

Birth Date

Sex (originally listed on birth certificate)

Female *Male* *Decline to Answer*

Social Security Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Home Phone Number

Please enter a valid phone number.

Cell Phone Number

Please enter a valid phone number.

Work Phone Number

Please enter a valid phone number.

Okay to leave voice message on Home Phone:

YES *NO*

Okay to leave voice message on Cell Phone:

YES *NO*

Primary Care Physician

Physician Phone Number

Please enter a valid phone number.

Physician Fax Number

Please enter a valid phone number.

Referred by

Self *Family* *Friend* *Physician/Healthcare Professional*

Name of Person Making Referral

Phone Number

Please enter a valid phone number.

Emergency Contact

First Name *Last Name*

Relationship

Phone Number

Please enter a valid phone number.

Local Pharmacy

Phone Number

Please enter a valid phone number.

Mail Order Pharmacy

Are you of Hispanic, Latino, or Spanish origin? *(The government requires us to collect this data)*

YES *NO* *Decline to Answer*

Please check box for ethnicity *(The government requires us to collect this data)*

African American/Black *Asian* *Caucasian/White* *Hispanic or Latino*

Native American *Other* *Decline to Answer*

Briefly describe your present symptoms *(Type in box below)*

Date symptoms began *(approx.)*

Are you *Right Handed* *Left Handed*

Past Medical History: *Please indicate if you have been diagnosed with any of the following medical conditions:*

Asthma/COPD *Cancer* *Diabetes* *Heart Disease* *High Cholesterol*

Hypertension *Osteoporosis* *Stroke* *Thyroid Disease*

Other conditions not listed

Please indicate previous rheumatological history

Conditions

Medications

Surgeries

Other physicians

Social History

Marital Status

Single *Married* *Widowed* *Divorced* *Separated* *Domestic Partner*

Your occupation

 # Hours / Week

Employer Name

Education

Please check the highest level attended

Grade School

7 *8* *9* *10* *11* *12*

College

1 *2* *3* *4* *Grad School*

Do you smoke?

YES *NO*

In the past? *Quit Date*

Do you drink caffeinated drinks?

YES *NO*

If yes, how many cups/glasses per day?

Do you drink alcohol?

YES *NO*

Number of drinks/week? *ex: 23*

Do you exercise regularly?

YES *NO*

Type of exercise?

Number of times/week *ex: 23*

Length of time *ex: 23*

Do you use street/recreational drugs?

YES *NO*

If yes please list

Hobbies?

Do you get enough sleep?

YES *NO*

Do you wake up feeling rested?

YES *NO*

Previous Surgeries: *Please include Procedure / Year / Notes for each surgery*

Previous hospitalizations other than surgeries: *Please include Reason / Year / Notes for each hospitalization*

Date of last bone densitometry?

Date of last colonoscopy?

Date of last mammogram?

Number of Pregnancies - *ex: 23*

Number of Deliveries - *ex: 23*

Number of Miscarriages/abortions - *ex: 23*

Family History

Father Age (if living) - *ex: 23*

Father Health (if living)

Father Age at death (if deceased) - *ex: 23*

Cause (if deceased)

Mother Age (if living) - *ex: 23*

Mother Health (if living)

Mother Age at death (if deceased) - *ex: 23*

Cause (if deceased)

Do you know of any blood relatives who have/have had: *(Check and give description)*

- ◯ *Rheumatoid Arthritis*
- ◯ *Systemic Lupus Erythematosus*
- ◯ *Psoriasis*
- ◯ *Inflammatory bowel disease*
- ◯ *Other Autoimmune Disease*
- ◯ *Hypertension*
- ◯ *Diabetes*
- ◯ *Heart Disease*
- ◯ *Stroke*
- ◯ *Cancer*
- ◯ *Other*

Provide details of any items checked above.

Drug Allergies

- ◯ *YES*
- ◯ *NO*

If yes, please specify *(Drug Name / Reaction)*

Please add any additional notes concerning drug reactions

Present Medications: *Please list all medications you are currently taking including Drug Name / Dose (Including strength and number of pills/day)*

Past Medications

Are you taking now or have you ever taken:

ANTI-RHEUMATIC DRUGS	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Azathioprine (Imuran)						
Cyclosphorine A (Neoral)						
Hydroxychloroquine (Plaquenil)						
Leflunomide (Arava)						
Methotrexate (Rhematrex)						
Mycophenolate (Cellcept)						
Sulfasazaline (Azulfidine)						
Adalimumab (Humira)						
Certilizumab (Cimzia)						
Etanercept (Enbrel)						
Golumumab (Simponi)						
Infliximab (Remicade)						
Abatacept (Orencia)						
Anakinra (Kineret)						
Apremilast (Otezla)						
Baricitinib (Olumiant)						
Ixekuzamab (Taltz)						
Secukinumab (Cosentyx)						
Tocilizumab (Actemra)						
Tofacitinib (Xeljanz)						
Ustekinumab (Rinvoq)						
Cyclophosphamide (Cytoxan)						
Rituximab (Rituxan)						

NON-STEROIDAL ANTI-INFLAMATORY DRUGS (NSAIDS)	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Aspirin (including coated aspirin)						
Celecoxib (Celebrex)						
Diclofenac (Voltaren)						
Etodolac (Lodine)						
Ibuprofen (Motrin)						
Indomethacin (Indocin)						
Meloxicam (Mobic)						

NON-STEROIDAL ANTI-INFLAMATORY DRUGS (NSAIDS) CONTINUED	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Nabumetone (Relafen)						
Naproxen (Naprosyn)						
Piroxicam (Feldene)						
Salsalate (Disalcid)						
Sulindac (Clinoril)						

PAIN RELIEVERS	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Codeine (Tylonel #3)						
Hydrocodone (Vicodin)						
Morphone (MS Contin)						
Oxycodone (Percocet)						
Tramadol (UIltram or Ultracet)						

OSTEOPEROSIS MEDICATIONS	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Abaloparatide (Tymlos)						
Alendronate (Fosamax)						
Denosumab (Prolia)						
Estrogen (Premarin, etc)						
Ibandronate (Boniva)						
Raloxifene (Evista)						
Risendronate (Actonel)						
Romosozumab (Evenity)						
Teriparatide (Foreto)						
Zoledronic acid (Reclast)						

GOUT MEDICATIONS	Dosage	Length of Time	Helped a lot	Helped some	Did not help at all	Reactions
Allopurinol						
Colchicine						
Febuxostat (Uloric)						
Probenecid						
OTHER RHEUMATILOGIC MEDICATIONS NOT LISTED						

Function

Please rate your overall assessment of how you perform on a daily basis:
On a scale of 1 to 10, 1 = very poorly & 10 = very well

◯ *1* ◯ *2* ◯ *3* ◯ *4* ◯ *5* ◯ *6* ◯ *7* ◯ *8* ◯ *9* ◯ *10*

On the scale below, please place a check mark next to the number that best describes your pain
On a scale of 1 to 10, 1 = no pain & 10 = pain as bad as it could be

◯ *1* ◯ *2* ◯ *3* ◯ *4* ◯ *5* ◯ *6* ◯ *7* ◯ *8* ◯ *9* ◯ *10*

Which joints are stiff?

After you wake up, how long does it take you to loosen up? *AM Stiffness in Minutes*

What are the hardest things for you to do?

Review of Symptoms

Please check any of these problems which have significantly affected you.

Constitutional

◯ *Night Sweats* ◯ *Weight Gain* ◯ *Loss of appetite* ◯ *Fever* ◯ *Weight Loss* ◯ *Fatigue*

Eye

◯ *Dry Eye* ◯ *Loss of Vision* ◯ *Eye Irritation or pain* ◯ *Blurring of vision*

ENT

◯ *Hearing Loss* ◯ *Ringing in ears* ◯ *Nosebleeds* ◯ *Rhinitis/conjunctivitis*

◯ *Sinus Pain* ◯ *Dry Mouth* ◯ *Mouth Sores* ◯ *Sore Throat*

Endocrinology

- ◯ *New hormone pills*
- ◯ *New thyroid problems*
- ◯ *Excessive thirst*
- ◯ *Polyuria/frequent urination*
- ◯ *Cold intolerance*
- ◯ *Heat intolerance*
- ◯ *Diabetes*

Respiratory

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

Cardiovascular

- ◯ *Syncope/fainting*
- ◯ *Dizziness*
- ◯ *Chest Pain*
- ◯ *Palpitations*
- ◯ *Leg edema*

Gastroenterology

- ◯ *Nausea*
- ◯ *Heartburn*
- ◯ *Vomiting*
- ◯ *Abdominal pain*
- ◯ *Dysphagia*
- ◯ *Diarrhea*
- ◯ *Constipation*
- ◯ *Blood in stool*

Hematology/Lymph

- ◯ *Anemia*
- ◯ *More infections than others*
- ◯ *Swollen glands*
- ◯ *Easy bruising*

Musculoskeletal

- ◯ *Joint pain*
- ◯ *Joint swelling*
- ◯ *Prior fracture*

Dermatology

- ◯ *New hair loss*
- ◯ *Allergy to sun*
- ◯ *Color change in cold/Raynaud*
- ◯ *Rash*
- ◯ *Skin cancer*

Neurology

- ◯ *Muscle weakness*
- ◯ *New headache*
- ◯ *Tingling/numbness of hands and feet*
- ◯ *Seizures*
- ◯ *Memory loss*
- ◯ *Loss of balance/falls*

Psychology

- ◯ *Insomnia*
- ◯ *Feeling blue or depressed*
- ◯ *Difficulty with sleep*
- ◯ *Mental or physical abuse*
- ◯ *Worries or anxiety*

Urology

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

Male reproductive

- ◯ *Risk for sexually transmitted disease/HIV*
- ◯ *Erectile dysfunction*
- ◯ *Penile discharge*

Female reproductive

- ◯ *Vaginal discharge or bleeding*
- ◯ *Menstrual irregularity*
- ◯ *Risk for sexually transmitted disease/HIV*
- ◯ *Contraception*

Financial Policy

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

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 copay 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/their primary care physician. Generally, an HMO will not allow us to see you without 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 assignments on all Medicare claims. Office visits are covered under Part B of the Medicare program. Medicare pays 80% 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 Rheumatic Disease Center. I agree that non-covered medical services are my responsibility. A photocopy of the agreement shall be authorized 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.

First Name

Last Name

Signature

Date