

Name: _____
 Chart: _____
 Date: _____



**AMERICAN COLLEGE OF
 RHEUMATOLOGY**
 EDUCATION • TREATMENT • RESEARCH
Patient History Form

Date of first appointment: _____ Time of appointment: _____ Birthplace: _____

Birthdate: _____

Address: _____ Age: _____ Sex: F M

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 week _____

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: _____

Do you have an orthopedic surgeon? Yes No Is yes, Name: _____

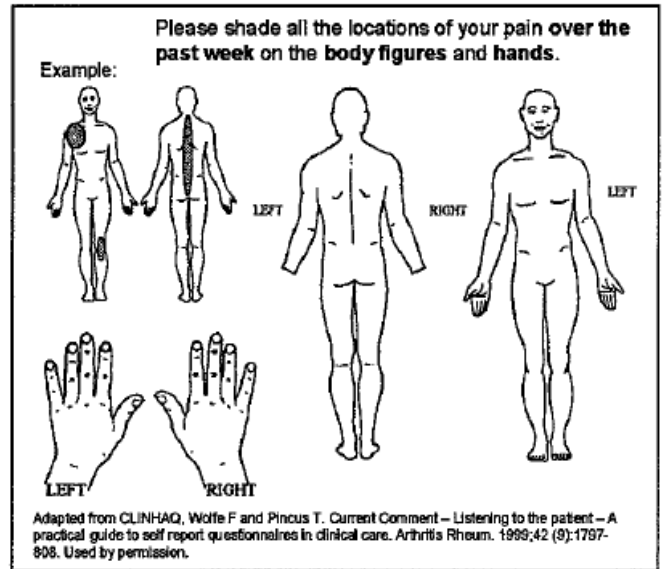
Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____ Example

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:



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
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

Patient's Name 0 Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those 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 in swallowing

Cardiovascular

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

Respiratory

- Shortness of breath
- Difficulty in 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

Previous Operations

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 deceased _____	
Number of children	_____	Number living _____	Number deceased _____	List ages of each _____
Health of children:	_____			

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Psoriasis _____ | |

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICAL HISTORY

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

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

Other significant illness (please list) _____

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

MEDICATIONS

Drug allergies: No Yes To what? _____

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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circle any you have taken in the past					
Ansaïd(flubiprofen) Arthrotec(diclofenac + misoprostil) Aspirin(including coated aspirin) Celebrex(celecoxib) Clinoril(suiindac)					
Daypro(oxaprozin) Disalcid(salsalate) Dolobid(diflunisal) Feldene(piroxicam) Indocin(indomethacin) Lodine(etodolac)					
Meclomen(meclofenamate) Motrin/Rufen(ibuprofen) Nalfon(fenoprofen) Naprosyn(naproxen) Oruvail(ketoprofen)					
Tolactin(tolmetin) Trilisate(choline magnesium trisalicylate) Vioxx(rofecoxib) Voltaren(diclofenac)					

Pain Relievers

Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Disease Modifying Antirheumatic Drugs (DMARDs)

Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allpurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others:					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

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

If yes, list: _____

Patient's Name _____ Date _____ Physician Initials _____



Office Use Only PT Acct # _____
www.durangoorthopedics.com

Durango Orthopedics Associates, P.C.

Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Durango Orthopedic Associates, P.C.

2. **Authorization for Release or Information:** Durango Orthopedic Associates, P.C. and my physician may release information from my medical records to any health care provider involved in my care and treatment, including Mercy Medical Center. Durango Orthopedic Associates, P.C. and my physician may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Durango Orthopedic Associates, P.C. is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Durango Orthopedic Associates, P.C. and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Durango Orthopedic Associates, P.C., I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Durango Orthopedic Associates, P.C.

4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Durango Orthopedic Associates, P.C. charges.

5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Durango Orthopedic Associates, P.C. and my physician for charges not paid.

I acknowledge that:

I have read this form and understand its contents

I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms

I am responsible for the payment and/or co-payment that is due at the time of service

Signature of Patient or Legally Responsible Person

Name (Print)

Relationship/Reason Why Patient is Unable to Sign

Date