

arthritis health

Rheumatology

Paul F. Howard, MD, FACP, FACR
Theresa J. Frimel NP-C

Yoga Therapy

Ginnie Livingston, RN, MSN, CYT

Dear Patient,

Thank you for your interest in rheumatic care at Arthritis Health. We are an integrative practice providing comprehensive care for all types of auto-immune, musculo-skeletal, and connective tissue disorders.

In order to prepare for your first visit, please fax, mail or drop off this form to Arthritis Health at least a week prior to your appointment. Additionally, please be sure your referring physician sends a referral letter along with all the following information at least one week prior to your appointment:

- Recent lab work
- Imaging studies or reports (X-rays, CT, MRI)
- Other pertinent medical information

Thank you again for your interest in working with us. We look forward to meeting you.

Sincerely,

Paul F. Howard, MD, FACP, FACR
Rheumatologist

Theresa J. Frimel NP-C

9097 E. Desert Cove Ave, Ste100
Scottsdale, Arizona 85260

Phone: 480-609-4200

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www.arthritishealth.net

PATIENT INFORMATION		
Last Name	First Name	Middle Initial
Address		
City, State Zip Code	Cell Phone Number	Home Phone Number
Date of Birth	Social Security Number	Work Phone Number
Sex	Marital Status	Email
Primary Care Physician First and Last Name	Primary Care Physician Phone Number	
Retail Pharmacy Name and Phone Number	Mail Order Pharmacy Name and Number	
PERSON RESPONSIBLE FOR CHARGES (GUARANTOR)		
Relationship of Patient to Guarantor If person responsible for payment is different from patient, then complete below. If patient is a child, please indicate if parents are	SELF MARRIED	SPOUSE SEPARATED
	CHILD	OTHER DIVORCED
Guarantor Name	Guarantor social Security Number	
Guarantor Address	Guarantor City, State Zip Code	
Guarantor Date of Birth	Guarantor Home Phone Number	Guarantor Office Number
Emergency Contact Name	Emergency Contact Phone Number	
RELEASE OF INFORMATION		
<p>I HEARBY AUTHORIZE Arthritis Health, LTD to release or retrieval of any information in the course of my examination and or treatment. I also authorize Arthritis Health access to my medical records and medication history during the course of my treatment. I hereby authorize payment directly to Arthritis Health, LTD for surgical and medical benefits, if any. I am financially responsible for all non-covered services, insurance denials and all services rendered without a referral, if my plan requires a referral for services rendered. I hereby agree to immediately pay all statements received from Arthritis Health, LTD for services rendered agree to pay interest on all past due accounts (over thirty days) at the rate of 1.5% per month/18% per annum, if it becomes necessary to put my account in the hands of a collection agency or attorney. I also agree to pay all such costs of collection and reasonable attorney's fees incurred.</p> <p>Signed _____ Date _____</p>		

arthritis health

Patient History Form

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 If yes, Name: _____

EDUCATION (circle highest level attended):

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

Occupation / Employer _____ Number of hours worked/average per week _____

If retired, previous occupation/employer _____ Year Retired _____

Disabled? Yes No Year disabled _____

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**.

Example:

The diagram shows four human figures and two hands. The first figure (front view) has a shaded area on the right shoulder. The second figure (back view) has a shaded area on the right shoulder blade. The third figure (back view) has a shaded area on the right lower back. The fourth figure (front view) has shaded areas on both wrists. The fifth figure (front view) has shaded areas on both wrists. The sixth figure (back view) has shaded areas on both wrists. Labels 'LEFT' and 'RIGHT' are placed next to the corresponding figures.

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
<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:			

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

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

MARITAL STATUS: Never Married Married Divorced
 Separated Widowed

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

Do you adhere to a special diet? Yes No
 Type _____

Do you exercise regularly? Yes No
 Type _____
 Amount per day _____; ___ x week = _____ minutes/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 _____ | |

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

Patient's Name _____ Date _____ Physician Initials _____

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"/>	
<p>Circle any you have taken in the past</p> <p> Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) </p>					
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) or Gold Shotes		<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"/>	
Leufleuamide (Arava)		<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"/>	
Adalimumab (Humira)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abatacept (Orencia)					
Rituximab (Rituxan)					
Other medications _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PAST MEDICATIONS Continued

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<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"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ibandronate (Boniva) – oral or IV		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zolindronic acid (Reclast) - IV		<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"/>	
Allopurinol (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:

What are the most important issues you would like addressed during your 1st visit at Arthritis Health?

1.

2.

3.

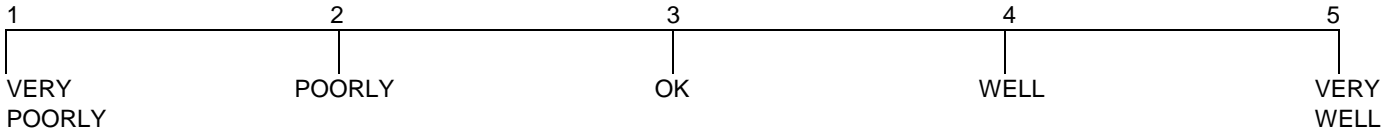
ACTIVITIES OF DAILY LIVING

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.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What is the hardest thing for you to do? _____			
Are you receiving disability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you applying for disability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you have a medically related lawsuit pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Arthritis Health's New Patient Cancellation/No Show Policy

We are happy that you have chosen Arthritis Health for your health care. While we understand that cancellations can sometimes be necessary, please note that we have great demands on our appointments. Therefore to ensure that you have a confirmed appointment, we reserve the right to charge a cancellation/no show fee according to our cancellation/no show policy.

Please note that timely cancellations will be accepted prior to 4:00 PM two days (48 hours) before the appointment. Cancellations after this time or not appearing for your appointment without appropriate notification will incur a cancellation/no show fee. The cancellation/no show fee for a new patient appointment is \$100.00 and will be billed to your account. This fee can be redeemed and will be applied to any future visit that you make within 60 days the fee was incurred.

By reserving your rheumatology appointment, you agree to the terms and conditions of our cancellation/no show policy. Please sign and return this form prior to your appointment along with the medical intake form.

We look forward to seeing you.

Thank you,

Your team at Arthritis Health.

Patient's Signature

Date