PATIENT REGISTRATION

COLORADO ARTHRITIS CENTER P.C.

PATIENT NAME(First, MI, Last) _____

HOME PHONE:_____CELL PHONE:_____WORK PHONE_____

ADDRESS:_____CITY:_____ST:____ZIP:_____

SEX: Male Female DATE OF BIRTH: _____AGE: _____MARITAL STATUS: M S D W

SOCIAL SECURITY#: _____-_____-_____ EMPLOYER: _____OCCUPATION: _____

RESPONSIBLE PARTY

NAME:_____ HOME PHONE#: _____

ADDRESS:_____ WORK PHONE#:_____

SOCIAL SECURITY#:_____-_____-_____ EMPLOYER:_____

RELATIONSHIP TO PATIENT: Self Spouse Sibling Parent Daughter Son Partner Other: _____

REFERRING PHYSICIAN

NAME:_____

ADDRESS:_____

PHONE#:_____FAX#:_____

PRIMARY PHYSICIAN

NAME:_____

ADDRESS:_____

PHONE#:_____FAX#_____

INSURANCE INFORMATION

PRIMARY INS:_____ SECONDARY INS:_____

INSURED NAME:_____ INSURED NAME:_____

INSURED DATE OF BIRTH: _____ INSURED DATE OF BIRTH: _____

MEMBER ID#_____ MEMBER ID#_____

GROUP#_____ GROUP#_____

RELATIONSHIP: SELF SPOUSE OTHER

RELATIONSHIP: SELF SPOUSE OTHER

EMERGENCY CONTACT(S)

NAME:_____ NAME:_____

PHONE:_____ PHONE:_____

RELATIONSHIP:_____ RELATIONSHIP:_____

EMAIL TO JOIN OUR PATIENT PORTAL

EMAIL ADDRESS: _____

PREFERRED PHARMACY

NAME: _____ PHONE:_____

ADDRESS: _____ FAX:_____

CITY, STATE, ZIP: _____

NAME:_____ PHONE:_____

ADDRESS: _____ FAX: _____

CITY, STATE, ZIP: _____

I hereby authorize Colorado Arthritis Center, P.C. to release any medical information to my insurance carrier, should my injury be work related. I authorize release of my medical information related to that injury to my employer or representative. I authorize my medical records to be released to any physician Colorado Arthritis Center refers me to.

SIGNATURE:_____ **DATE:**_____

I authorize payment of medical benefits directly to Colorado Arthritis Center, P.C. for all services rendered and agree to pay any unpaid balance left by my insurance company.

SIGNATURE:_____ **DATE:** _____

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex F M

Marital status: ❑ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

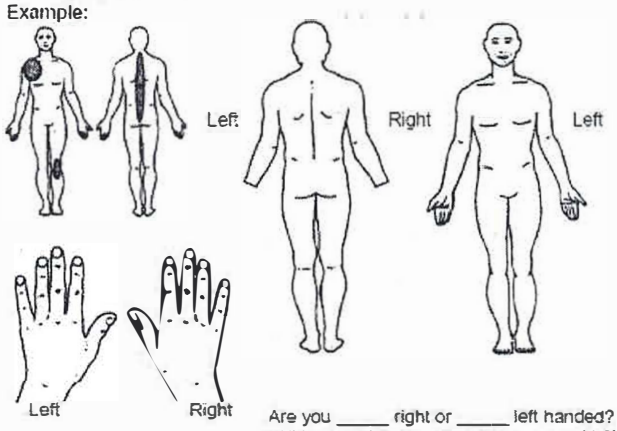
Whom do we thank for referring you here? _____

Name of your primary care physician: _____

Describe briefly your present symptoms: _____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

Physician initials _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	☐	☐	→	_____
Osteoarthritis	☐	☐	→	_____
Rheumatoid arthritis	☐	☐	→	_____
Gout	☐	☐	→	_____
Lupus or "SLE"	☐	☐	→	_____
Ankylosing spondylitis	☐	☐	→	_____
Childhood arthritis	☐	☐	→	_____
Sjogren's syndrome	☐	☐	→	_____
Osteoporosis	☐	☐	→	_____
Psoriasis/psoriatic arthritis	☐	☐	→	_____

PAST MEDICAL HISTORY

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

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Hypothyroidism
☐ Goiter
☐ Cancer (type) _____
☐ Leukemia
☐ Psoriasis
☐ Angina
☐ Heart problems
☐ Heart murmur
☐ Pneumonia
☐ Pulmonary embolism
☐ Asthma
☐ Emphysema
☐ Stroke
☐ Epilepsy (seizures)
☐ Cataracts
☐ Kidney disease
☐ Kidney stones
☐ Crohn's disease
☐ Colitis
☐ Anemia
☐ Jaundice
☐ Hepatitis
☐ Stomach or peptic ulcer
☐ Rheumatic fever
☐ Tuberculosis
☐ HIV/AIDS

Other significant illnesses (please list): _____

_____

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 _____

Do you smoke? ☐ Yes – How much? _____ ☐ No ☐ In the past - How long ago? _____

Do you drink alcohol? ☐ No ☐ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking ☐ Yes ☐ No

Do you use drugs for reasons that are not medical ☐ No ☐ Yes If yes, please list: _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Physician initials _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

What medications have you taken previously? _____

PERSONAL HISTORY

What is your highest educational level? ☐ High school ☐ Some college courses ☐ College graduate ☐ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ☐ Yes ☐ No If yes, hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability? _____

What date did this disability begin? _____

With whom do you currently live? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

_____

Physician initials _____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Morning stiffness
  Lasting how long ____ Minutes
  ____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE
- ☐ Nosebleeds
- ☐ Loss of smell

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK
- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

KIDNEY/URINE/BLADDER
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Frequent urination
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

BLOOD
- ☐ Anemia
- ☐ Bleeding tendency

SKIN
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
☐ No ☐ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ☐ Yes ☐ No
How many days apart? _____

Physician initials _____

CORRONA modified HEALTH ASSESSMENT (mHAQ)
PATIENT QUESTIONNAIRE

Site ID _____

Patient ID _____ - _____ - _____

Date _____

Please mark the one response which best describes your usual abilities over the past few days:

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
1.) Dress yourself, including tying shoelaces and doing buttons?	_____	_____	_____	_____
2.) Get in and out of bed?	_____	_____	_____	_____
3.) Lift a full cup or glass to your mouth?	_____	_____	_____	_____
4.) Walk outdoors on flat ground?	_____	_____	_____	_____
5.) Wash and dry your entire body?	_____	_____	_____	_____
6.) Bend down and pick up clothing from the floor?	_____	_____	_____	_____
7.) Turn regular faucets on and off?	_____	_____	_____	_____
8.) Get in and out of the car?	_____	_____	_____	_____

SUBJECT ASSESSMENT OF PAIN & DISEASE ACTIVITY

PAIN: How much pain have you had because of your arthritis? Put a mark on the scale (like this |) to show how severe your pain has been.

NO PAIN _____ PAIN AS BAD AS IT COULD BE

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

DISEASE ACTIVITY: Considering all the ways arthritis affects you, put a mark on the scale (like this |) to show how well you are doing.

VERY WELL _____ VERY POORLY

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

SKIN DISEASE ACTIVITY (**Psoriasis Patients Only**) Put a mark on the scale (like this |) to show the activity of your **SKIN** DISEASE ONLY.

VERY WELL _____ VERY POORLY

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

2007-10-15 Bsl. mHAQ v.7

Physician initials _____