R&O RHEUMATOLOGY&OSTEOPOROSIS services p.c.

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

1520 South 70th Street, Suite 200
Lincoln, Nebraska 68506
Tel: (402)464-9000 Fax: (402)464-4447
www.rheumatologyandosteoporosis.com

Amy S. Garwood, M.D.
Jennifer R. Elliott, M.D.
Kayla B. Bruss, MPAS, PA-C
Molly B. Skomer, APRN
Jennifer M. Livermore, APRN
Kelsey L. Baxa, APRN

PLEASE USE BLUE OR BLACK INK ONLY

Patient Name _____
Last First Middle Initial Maiden

Preferred name if different than above_____ Birthdate: _____/_____/_____ Age:_____

Address_____ Social Security #_____

City_____ State_____ Zip Code_____ Birthplace:_____

Telephone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email Address:_____ Preferred Method of Contact: Home Work Cell

Sex: ☐ Male ☐ Female **Are you:** ☐ Right Hand Dominant ☐ Left Hand Dominant ☐ Ambidextrous

Primary Language (circle one): English Other_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐American Indian or Alaska Native ☐Asian ☐ Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Spouse/Significant other: ☐ Alive/Age_____ ☐ Deceased/Age_____ Major Illnesses_____

Name of Spouse _____ Spouse Date of Birth _____/_____/_____

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

Current Work Status: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Full-time ☐ Part-time # of hours worked/average per week_____

Place of Employment_____ Occupation_____

EMERGENCY CONTACT: 1) Name_____ Relationship_____

Phone Number(s)_____

2) Name_____ Relationship_____

Phone Number(s)_____

REFERRAL: Referred here by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Heath Professional

Name of person making referral_____

Primary Care Physician (PCP)_____

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

PREFERRED PHARMACY:

Local_____ Location_____

Mail Order_____ Location_____

Patient's Name_____ Date_____ MD Initials_____

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**)_____

_____

_____

_____

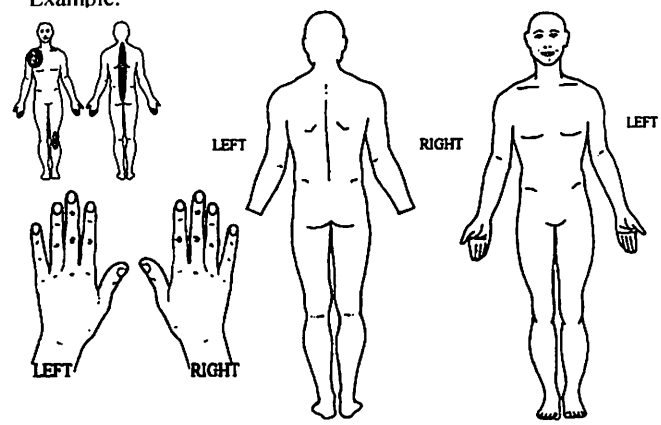
Please list the names of other practitioners you have seen for this problem:

_____

_____

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

Example:



PREVIOUS OPERATIONS

Type of Surgery	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ☐ Yes ☐ No Describe:_____

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

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
	Ankylosing Spondylitis			Lupus or SLE	
	Arthritis (unknown type)			Osteoarthritis	
	Childhood arthritis			Osteoporosis	
	Gout			Rheumatoid Arthritis	
Other arthritis conditions:					

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:_____

Patient's Name_____ Date_____ MD Initials_____

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

☐ Alcoholism_____ ☐ Colitis_____ ☐ High blood pressure_____ ☐ Rheumatic Fever_____

☐ Asthma_____ ☐ Diabetes_____ ☐ Leukemia_____ ☐ Stroke_____

☐ Bleeding tendency_____ ☐ Epilepsy_____ ☐ Miscarriage_____ ☐ Thyroid disorder_____

☐ Blood clots_____ ☐ Fibromyalgia_____ ☐ Psoriasis_____ ☐ Tuberculosis_____

☐ Cancer_____ ☐ Heart Disease_____

Any other conditions that run in your family?_____

_____

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No

Cups/glasses per day_____

Do you smoke? ☐ Yes ☐ No ☐ Past smoker

When did you quit?_____ How many per day?_____

How many cigarettes per day?_____

Do you drink alcohol? ☐ Yes ☐ No # drinks/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

Are you receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

Do you have a medically related lawsuit pending? ☐ Yes ☐ No

Date of last mammogram_____/_____/_____

Date of last eye exam _____/_____/_____

Date of last chest x-ray _____/_____/_____

Date of last bone densitometry (DXA) _____/_____/_____

PAST MEDICAL HISTORY

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

☐ Anemia	☐ Fibromyalgia	☐ Leukemia
☐ Bad headaches	☐ Glaucoma	☐ Liver disease
☐ Blood clots	☐ Goiter	☐ Nervous breakdown
☐ Breathing problems	☐ Heartburn	☐ Psoriasis
☐ Cancer	☐ Heart problems	☐ Rheumatic Fever
☐ Cataracts	☐ High blood pressure	☐ Sleep apnea
☐ Colitis	☐ High cholesterol	☐ Stomach ulcers
☐ Depression/Anxiety	☐ HIV/AIDS	☐ Stroke
☐ Diabetes	☐ Jaundice	☐ Thyroid disorder
☐ Epilepsy	☐ Kidney disease	☐ Tuberculosis

Other significant illness (please list)_____

_____

_____

What is your form of birth control?_____

Do you drive? ☐ Yes ☐ No

What is your current living situation (circle one):

House/Duplex Apartment Assisted Living Nursing Home

Other_____

Date of last colonoscopy _____/_____/_____

Date of last dental exam _____/_____/_____

Date of last Tuberculosis test _____/_____/_____

Location?_____

Vaccinations: Influenza/Flu ☐ Yes ☐ No Date:_____ Shingles ☐ Yes ☐ No Date:_____

Pneumonia ☐ Yes ☐ No Date:_____ DTaP ☐ Yes ☐ No Date:_____

Patient's Name_____ Date_____ MD Initials_____

SYSTEMS REVIEW

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

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight gain Amount_____
- ☐ Recent weight loss Amount_____
- ☐ Weakness

Eyes
- ☐ Double or blurred vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Eye redness
- ☐ Feels like something in eye
- ☐ Itchy eyes
- ☐ Loss of vision
- ☐ Vision changes
- ☐ Watery eyes

Ear-Nose-Mouth-Throat
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Dry nose
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Runny nose
- ☐ Sinus trouble
- ☐ Sores in mouth or nose
- ☐ Sore tongue

Cardiovascular
- ☐ Chest pain
- ☐ Fluid around heart or pericarditis
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat

Respiratory
- ☐ Cough
- ☐ Coughing of blood
- ☐ Difficulty in breathing at night
- ☐ Fluid around lung or pleurisy
- ☐ Pain with breathing
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Swollen legs or feet
- ☐ Wheezing (asthma)

Gastrointestinal
- ☐ Black stools
- ☐ Blood in stools (or bright red)
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting

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

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? _____
Have you ever taken estrogen? ☐ Yes ☐ No
If so, how long?_____

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness

Lasting how long?
_____Minutes _____ Hours
- ☐ Muscle tenderness
- ☐ Muscle weakness

List joints affected in the last 6 months:

_____
_____
_____
_____
_____

Integumentary (skin)
- ☐ Color changes of hands or feet in the cold
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Hives
- ☐ Nodules/bumps
- ☐ Pigment changes to skin
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin redness
- ☐ Skin tightness
- ☐ Sun sensitivity

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Loss of consciousness
- ☐ Memory loss
- ☐ Muscle spasms
- ☐ Night sweats
- ☐ Numbness or tingling
- ☐ Restless legs
- ☐ Sensitivity or pain of hands and/or feet

Psychiatric
- ☐ Agitation
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Easily losing temper
- ☐ Excessive worries

Endocrine
- ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Swollen glands
- ☐ Tender glands
- ☐ Transfusion

If yes, When?_____

Allergic/Immunologic
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name_____ Date_____ MD Initials_____

ALLERGIES (medications, latex, food, etc.)

Allergic to	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

PRESENT MEDICATIONS (list any medications you are taking. Include such items as aspirin, laxatives, calcium and other supplements)

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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS (Please review this list of "rheumatology" 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 Generic (Brand) Names	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at All	
Prednisone (Deltasone, Rayos) or Methylprednisolone (Medrol)		☐	☐	☐	
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)					
Aspirin		☐	☐	☐	
Celecoxib (Celebrex)		☐	☐	☐	
Diclofenac (Voltaren, Voltaren Gel, Arthrotec, Flector Patch, Pennsaid, Zorvolex)		☐	☐	☐	
Diflunisal (Dolobid)		☐	☐	☐	
Etodolac (Lodine)		☐	☐	☐	
Fenoprofen (Nalfon)		☐	☐	☐	

Patient's Name_____ Date_____ MD Initials_____

Drug names/Dosage Generic (Brand) Names	Length of time	Please check: Helped? A Lot	Some	Not at All	Reactions
Flurbiprofen (Ansaid)		☐	☐	☐	
Ibuprofen (Motrin, Duexis)		☐	☐	☐	
Indomethacin (Indocin)		☐	☐	☐	
Ketoprofen (Orudis, Oruvail)		☐	☐	☐	
Ketorolac (Toradol)		☐	☐	☐	
Meclomen (Meclofenamate, Meclofenamic Acid)		☐	☐	☐	
Mefenamic Acid (Ponstel)		☐	☐	☐	
Meloxicam (Mobic)		☐	☐	☐	
Nabumetone (Relafen)		☐	☐	☐	
Naproxen (Aleve, Anaprox, Naprosyn, Naprelan, Vimovo)		☐	☐	☐	
Oxaprozin (Daypro)		☐	☐	☐	
Piroxicam (Feldene)		☐	☐	☐	
Salsalate (Amigesic, Disalcid)		☐	☐	☐	
Sulindac (Clinoril)		☐	☐	☐	
Tolmetin (Tolectin)		☐	☐	☐	
No Longer Available: Rofecoxib (Vioxx) and Valdecoxib (Bextra)		☐	☐	☐	
DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)					
Methotrexate (Trexall, Rheumatrex)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Leflunomide (Arava)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Minocycline (Minocin, Solodyn)		☐	☐	☐	
Doxycycline (Vibramycin, Doryx, Oracea, Monodox)		☐	☐	☐	
Auranofin (Ridaura) or Gold Shots (Myochrysine)		☐	☐	☐	
Azathioprine (Imuran, Azasan)		☐	☐	☐	
Mycophenolate Mofetil (Cellcept)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Penicillamine (Cuprimine, Depen)		☐	☐	☐	
Cyclosporine A (Sandimmune, Neoral)		☐	☐	☐	
Tacrolimus (Prograf)		☐	☐	☐	
BIOLOGICS					
Etanercept (Enbrel)		☐	☐	☐	
Adalimumab (Humira)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Golimumab (Simponi)		☐	☐	☐	

Patient's Name_____ Date_____ MD Initials_____

Drug names/Dosage Generic (Brand) Names	Length of time	Please check: Helped? A Lot	Some	Not at All	Reactions
Certolizumab Pegol (Cimzia)		☐	☐	☐	
Rituximab (Rituxan)		☐	☐	☐	
Abatacept (Orencia)		☐	☐	☐	
Tocilizumab (Actemra)		☐	☐	☐	
Anakinra (Kineret)		☐	☐	☐	
Tofacitinib (Xeljanz)		☐	☐	☐	
Belimumab (Benlysta)		☐	☐	☐	
Ustekinumab (Stelara)		☐	☐	☐	
Intravenous Immunoglobulin (IVIg)		☐	☐	☐	
OSTEOPOROSIS MEDS					
Alendronate (Fosamax)		☐	☐	☐	
Ibandronate (Boniva)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Zoledronic Acid (Reclast, Zometa)		☐	☐	☐	
Pamidronate (Aredia)		☐	☐	☐	
Teriparatide (Forteo)		☐	☐	☐	
Denosumab (Prolia)		☐	☐	☐	
Calcitonin (Miacalcin)		☐	☐	☐	
Estrogen or Hormone Replacement Therapy		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
GOUT MEDS					
Colchicine (Colcrys)		☐	☐	☐	
Allopurinol (Aloprim, Lopurin, Zyloprim)		☐	☐	☐	
Febuxostat (Uloric)		☐	☐	☐	
Probenecid (Probalan)		☐	☐	☐	
Pegloticase (Krystexxa)		☐	☐	☐	
PAIN MEDS					
Acetaminophen (Tylenol)		☐	☐	☐	
Amitriptyline (Elavil)		☐	☐	☐	
Buprenorphine (Butrans)		☐	☐	☐	
Codeine		☐	☐	☐	
Duloxetine (Cymbalta)		☐	☐	☐	
Fentanyl (Duragesic)		☐	☐	☐	
Gabapentin (Neurontin, Horizant, Gralise)		☐	☐	☐	
Hydrocodone (Anexsia, Ibudone, Lorcet, Lortab, Maxidone, Norco, Vicodin, Vicoprofen, Xodol, Zydone)		☐	☐	☐	
Hydromorphone (Dilaudid)		☐	☐	☐	

Patient's Name_____ Date_____ MD Initials_____

Drug names/Dosage Generic (Brand) Names	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at All	
Meperidine (Demerol)		☐	☐	☐	
Methadone		☐	☐	☐	
Milnacipran (Savella)		☐	☐	☐	
Morphine (MS Contin, Kadian, Avinza, Roxanol, MSIR)		☐	☐	☐	
Nortriptyline (Aventyl, Pamelor)		☐	☐	☐	
Oxycodone (Combunox, Magnacet, Percocet, Percodan, Roxicet, Roxicodone, OxyContin, OxyIR, Tylox)		☐	☐	☐	
Oxymorphone (Opana)		☐	☐	☐	
Pregabalin (Lyrica)		☐	☐	☐	
Tapentadol (Nucynta)		☐	☐	☐	
Tramadol (Ultracet, Ultram)		☐	☐	☐	
JOINT INJECTIONS					
Steroids		☐	☐	☐	
Hyaluronic Acid (Euflexxa, Gel-One, Hyalgan, Orthovisc, Supartz, Synvisc)		☐	☐	☐	
MUSCLE RELAXANTS					
Baclofen (Lioresal, Kemstro)		☐	☐	☐	
Carisoprodol (Soma)		☐	☐	☐	
Cyclobenzaprine (Flexeril, Fexmid)		☐	☐	☐	
Metaxaolne (Skelaxin)		☐	☐	☐	
Methocarbamol (Robaxin)		☐	☐	☐	
Orphenadrine (Norflex)		☐	☐	☐	
Tizanidine (Zanaflex)		☐	☐	☐	
NUTRITIONAL SUPPLEMENTS					
Calcium		☐	☐	☐	
Vitamin D		☐	☐	☐	
Glucosamine Chondroitin		☐	☐	☐	
Fish Oil		☐	☐	☐	
Turmeric		☐	☐	☐	
Others:		☐	☐	☐	
MISC					
Cevimeline (Evoxac)		☐	☐	☐	
Cyclosporine eye drops (Restasis)		☐	☐	☐	
Pilocarpine (Salagen)		☐	☐	☐	

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

If yes, please list_____

Natural or Alternative Therapies (chiropractic, acupuncture, massage, over-the-counter supplements, etc.)

_____

Patient's Name_____ Date_____ MD Initials_____