Florida Arthritis and Osteoporosis Center

1600 Budinger Ave # A, St Cloud, FL 34769
Tel (407)392 0300 Fax (407)392 0301

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: _____

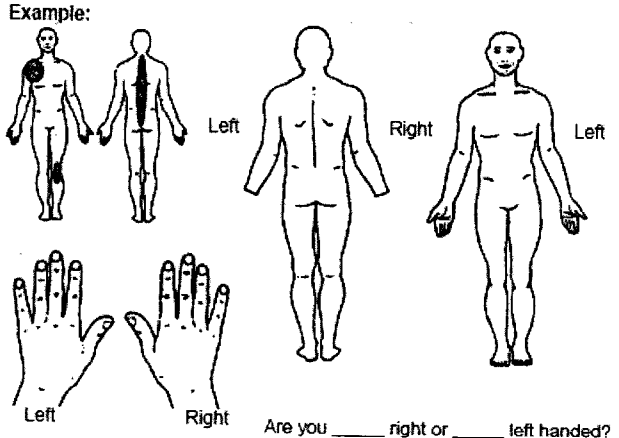
Describe briefly your present symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any?

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?)

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):

For New Patients: We do not prescribe narcotics or controlled substances on your first visit.

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 ❑ 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

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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.	

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: _____

_____

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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? _____

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NEW PATIENT PACKET

PATIENT INFORMATION – PLEASE PRINT

NAME (Last, First, Middle)	BIRTHDATE (MM/DD/YYYY) / /	SSN	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP		

RACE	LANGUAGE	EHNICITY	PHARMACY NAME:
		☐HISPANIC ☐NON-HISPANIC ☐OTHER	PHONE: ( ) -

EMPLOYER'S NAME / EMPLOYER'S ADDRESS / OCCUPATION — REFERRED BY

☐ **YES** *I allow **Florida Arthritis and Osteoporosis Center** to **MAIL** medical information to the above address.*
☐ **NO** *I don't allow **Florida Arthritis and Osteoporosis Center** to **MAIL** medical information to the above address.*

*I allow **Florida Arthritis and Osteoporosis Center** to **CALL** me on the specified number(s).*

HOME PHONE ( ) - CELL PHONE ( ) - WORK PHONE ( ) -

EMAIL ADDRESS

☐ **YES** *I allow **Florida Arthritis and Osteoporosis Center** to **EMAIL** me.*
☐ **NO** *I don't allow **Florida Arthritis and Osteoporosis Center** to **EMAIL** me.*
**Enrollment is mandatory. We may not email you through your regular email address.(please check 'YES' or 'NO').*

ADVANCED DIRECTIVE / LIVING WILL

In the event you become unable to tell your physician and family how you want to be treated, federal and state laws provide ways for you to make your wishes known. The Federal Patient Self Determination Act states that each competent adult patient has the right to prepare a written "Advanced Directive" regarding healthcare decisions. The advanced directive is typically expressed in one or more of three basic types or forms; a Living Will declaration, a Durable Power of Attorney for healthcare, or a Designation of Healthcare Surrogate, or representative to make healthcare decisions for you, the patient when the patient becomes incapable of making those decisions.

☐ I **DO have** a Living Will and will present it to my Physician ☐ I do **NOT** have a Living Will prepared at this time

CONSENT FOR TREATMENT

I hereby give consent to **Florida Arthritis and Osteoporosis Center** to provide whatever treatment they may deem necessary to treat the patient above

By signing below, I acknowledge everything mentioned above is accurate and true. I also acknowledge that I have read and understood the **Financial Policy** that is provided at the end of this packet.

_____ _____/_____/_____
PATIENT / RESPONSIBLE PARTY (SIGN & PRINT) DATE

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Assignment of Benefits

INSURANCE POLICY HOLDER – PLEASE PRINT		
NAME (Last, First, Middle)	(*If not patient*) SSN :	(*If not patient*) BIRTHDATE (MM/DD/YYYY) / /
(*If not patient*) LOCAL ADDRESS CITY, STATE, ZIP		RELATIONSHIP TO PATIENT:
(*If not patient*) PHONE NUMBER TO CONTACT P: ( ) -	OCCUPATION	EMPLOYER

I hereby instruct and direct _____ ***(name of insurance company)*** to pay by check made out and mailed to:

Florida Arthritis and Osteoporosis Center
1600 Budinger Ave #A, St Cloud, FL 34769
(407)392 0300 TEL
(407)392 0301 FAX

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT- OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above the insurance payment.

Release of responsibility:

It is therefore my sole responsibility as the patient to know my insurance company coverage, including which laboratory, medical provider or facilities my insurance company is contracted with. I will not hold Florida Arthritis and Osteoporosis Center and its management responsible for any bills incurred regarding any expenses or errors pertaining to me going to a non-covered laboratory, medical provider or facilities.

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Signature of Policyholder / Patient Date

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HIPAA UPDATE 2014
EMERGENCY CONTACT INFORMATION

NAME (Last, First, Middle)	SSN	BIRTHDAY (MM/DD/YYYY) / /	GENDER

Name	Relationship	Home Phone ( ) -	Cell Phone ( ) -

Street Address	City	State	Zip

PATIENT RECORD OF DISCLOSURES

In general, the **HIPAA privacy rule** gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that all communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I authorize **Florida Arthritis and Osteoporosis Center** to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

**Please list and specify your best contact numbers:*

PRIMARY NO.: (_____)_____-_____

SECONDARY NO.: (_____)_____-_____

***Please list other numbers we may contact you on:*

(_____)_____-_____

☐ Written Communication *(Please check all that apply)*

- ☐ O.K. to mail to my local address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number: _____
- ☐ Email address

****CONFIDENTIALITY CLAUSE**

I authorize the VERBAL and/or WRITTEN release of my information and test results to my specified person(s) in the event that I am not available:

☐ YES, others can access my information *(if yes, please list person(s) below)*

☐ NO, no one is allowed

	Full Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I have received the **Notice of Privacy Practices** pamphlet and I have been provided the opportunity to review it.

Signature: _____ Date: _____

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AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Social Security# (last 4 digits): _____

Address: _____

Date of Birth: _____/_____/_____ Phone#: _____

Identification Shown: _____ Mail Pick up: Paper CD

I hereby authorize **Florida Arthritis and Osteoporosis Center** to use and disclose or obtain from :

_____ _____
Name of Facility or Person Phone/Fax

_____
Address

The following information contained in my medical record regarding my illness, care and treatment (please initial):

_____ Complete Record	_____ All Diagnostic Test Results	_____ Pathology Report/(s)
_____ Abstract of Record	_____ Consultation	_____ Lab only
_____ Therapy Records	_____ Radiology only	_____ Other (Please specify)
_____ Progress Note(s)	_____ Operative Report	_____

The purpose for the release of information at the request of the individual is:

Insurance Legal Action Continued Treatment Personal Use

Other (please specify) _____

This authorization will expire on the following date, event or condition: _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initiated or otherwise required by law.

May NOT include information related to (please initial):

_____ HIV/AIDS _____ Mental Health Drug and/or Alcohol Abuse _____Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that **Florida Arthritis and Osteoporosis Center** may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Date/Time