

Arthritis Center of Nebraska  
3901 Pine Lake Road, Ste 120  
Lincoln, NE 68516-5497  
402-420-1212



PATIENT ACCOUNT# \_\_\_\_\_ DR \_\_\_\_\_

Family Physician \_\_\_\_\_ Referred by \_\_\_\_\_

PLEASE PRINT CLEARLY with BLACK or BLUE pen

APPOINTMENT DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  
First MI Last

\*\*NAME PREFERRED TO BE CALLED \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail address \_\_\_\_\_

TELEPHONE #'s Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

SEX  Female  Male  Transgender Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo day yr Marital Status  Single  Married  Widowed  Divorced  
 Separated  Domestic Partner

SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_  Full-Time  Part-time

**IN CASE OF EMERGENCY NOTIFY:**

**IF MARRIED-SPOUSE**

NAME \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
mo day yr

**ADDITIONAL EMERGENCY CONTACT NOT RESIDING WITH YOU \_\_\_\_\_**

Relationship to patient \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**\*\*THE GOVERNMENT IS REQUIRING US TO COLLECT THIS DATA - Please answer BOTH questions below about Hispanic Origin and Race \*\***

**Are you Hispanic, Latino or Spanish in Origin? Please Note: Hispanic origins are not races.**

- No, not of Hispanic, Latino or Spanish Origin
- Yes, Hispanic
- Yes, Mexican
- Yes, Mexican American
- Yes, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other

**Please select your race:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Chinese                | <input type="checkbox"/> Vietnamese            |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Filipino               | <input type="checkbox"/> Native Hawaiian       |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese               | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Samoan                |
| <input type="checkbox"/> Other Race                       | <input type="checkbox"/> Other Pacific Islander |  |

Primary Language Spoken: \_\_\_\_\_

**INSURANCE INFORMATION**  
**Please be exact in listing identification numbers**

**Primary Insurance** Co. Name \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Patient relationship to insured:**    **Self**    **Spouse**    **Child**    **Other** \_\_\_\_\_

If relationship to insured "Other than Self" please complete below:

**Policy Holder**   Name \_\_\_\_\_  
(Insured)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # of Policy Holder \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ Employer \_\_\_\_\_

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**Secondary Insurance** Co. Name \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Patient relationship to insured:**    **Self**    **Spouse**    **Child**    **Other** \_\_\_\_\_

If relationship to insured "Other than Self" please complete below:

**Policy Holder**   Name \_\_\_\_\_  
(Insured)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # of Policy Holder \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_ Employer \_\_\_\_\_

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**Tertiary Insurance** Co. Name \_\_\_\_\_  
(3<sup>rd</sup> Insurance if applicable)

ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Patient relationship to insured:**    **Self**    **Spouse**    **Child**    **Other** \_\_\_\_\_

If relationship to insured "Other than Self" please complete below:

**Policy Holder**   Name \_\_\_\_\_  
(Insured)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # of Policy Holder \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_ Employer \_\_\_\_\_

**PRIOR AUTHORIZATION/REFERRAL FOR INSURANCE**

It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

**AUTHORIZATION TO RELEASE INFORMATION**

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM (Please sign your name below). I hereby authorize photocopies of this form to be as valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing. I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pendency of insurance claims.

Date \_\_\_\_\_ **X** \_\_\_\_\_

***Patient's or authorized person's signature***



# ARTHRITIS CENTER OF NEBRASKA

## Patient History Form

Pt # \_\_\_\_\_

Date of first appointment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time of appointment: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
MONTH DAY YEAR

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
STREET APT #

\_\_\_\_\_  
CITY STATE ZIP Telephone: Home (\_\_\_\_\_) \_\_\_\_\_  
Work (\_\_\_\_\_) \_\_\_\_\_

**MARITAL STATUS:**  Never Married  Married  Divorced  Separated  Widowed

Spouse/Significant Other:  Alive/Age \_\_\_\_\_  Deceased/Age \_\_\_\_\_ Major Illnesses \_\_\_\_\_

Spouse Occupation: \_\_\_\_\_

### 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 \_\_\_\_\_

How did you hear about our clinic?  Newspaper  Yellow Pages  Health fair  Radio  Arthritis lecture  Other

Referred here by: (check one)  Self  Family  Friend  Doctor  Other health professional

Name of person making referral: \_\_\_\_\_

Name of the physician providing your primary medical care: \_\_\_\_\_ Name of city the MD is located in: \_\_\_\_\_

Do you have an orthopedic surgeon?  Yes  No If yes, name: \_\_\_\_\_

Name of physician you will be seeing today \_\_\_\_\_

Describe briefly your present symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date symptoms began (approximate) \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Indicate below any previous treatment for this problem

(medications to be listed later):

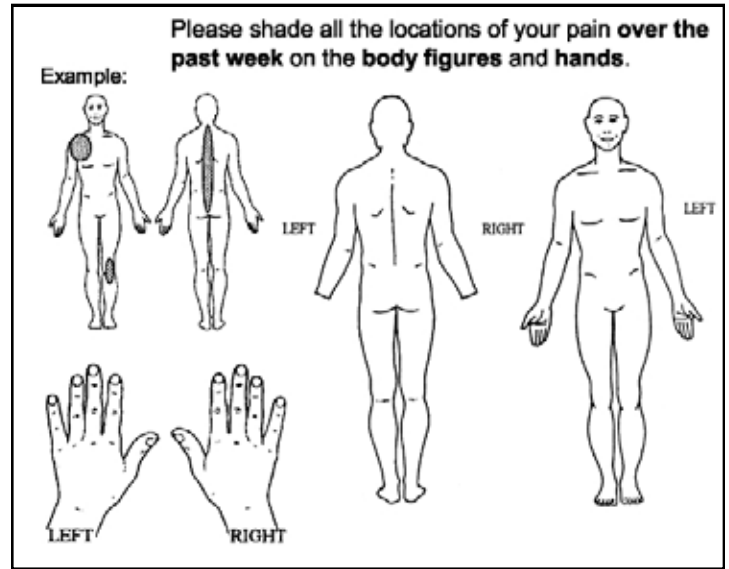
Physical therapy \_\_\_\_\_

Injections \_\_\_\_\_

Surgery \_\_\_\_\_

Please list the names of the 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)	<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: \_\_\_\_\_

**CURRENT MEDICATIONS**

Drug allergies:     No         Yes

To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**CURRENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, 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.			<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"/>
11.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

If yes list: \_\_\_\_\_

**PAST MEDICAL HISTORY**

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Colitis            | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Sleep apnea       |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach ulcers     | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Emphysema         |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Leukemia           |  |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Bad headaches      |  |

Other significant illness (please list) \_\_\_\_\_

Natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Do you drink caffeinated beverages?  Yes  No  
 If yes, how many cups/glasses per day? \_\_\_\_\_

Are you a:  
 Nonsmoker  
 Current smoker  Every day  Some days, but not every day  
 How many cigarettes a day do you smoke? \_\_\_\_\_  
 How soon after you wake up do you smoke your first cigarette? \_\_\_\_\_minutes  
 Are you interested in quitting?  Ready  Thinking about it  Not ready  
 Former Smoker  
 How long has it been since you last smoked? \_\_\_\_\_  
 Do you smoke a pipe? \_\_\_\_\_  
 Do you chew tobacco? \_\_\_\_\_

Do you use street/recreational drugs?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you drink alcohol?  Yes  No Number per week \_\_\_\_\_  
 Has anyone ever told you to cut down on your drinking?  
 Yes  No

Do you exercise regularly?  Yes  No  
 Type of exercise \_\_\_\_\_  
 Number of times per week \_\_\_\_\_ Length of time in min. \_\_\_\_\_

Hobbies \_\_\_\_\_

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: \_\_\_\_\_

Any hospitalizations – other than surgeries?  No  Yes Describe: \_\_\_\_\_

**FAMILY HISTORY**

	Age	IF LIVING Health	IF DECEASED 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)**

- Alcoholism \_\_\_\_\_  Colitis \_\_\_\_\_  Heart disease \_\_\_\_\_  Rheumatic fever \_\_\_\_\_
- Asthma \_\_\_\_\_  Diabetes \_\_\_\_\_  High blood pressure \_\_\_\_\_  Stroke \_\_\_\_\_
- Bleeding tendency \_\_\_\_\_  Epilepsy \_\_\_\_\_  Leukemia \_\_\_\_\_  Tuberculosis \_\_\_\_\_
- Cancer \_\_\_\_\_  Goiter \_\_\_\_\_  Psoriasis \_\_\_\_\_

**SYSTEMS REVIEW**

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\_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last flu immunization\_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last pneumonia vaccination \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last tetanus (DTap) \_\_\_\_/\_\_\_\_/\_\_\_\_

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

<p><b>Constitutional</b></p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Weight gain ____lb</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight loss ____lb</p> <p><input type="checkbox"/> Fatigue / Weakness</p> <p align="center"><b>Allergy</b></p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Nasal polyps</p> <p><input type="checkbox"/> Rhinitis/ conjunctivitis</p> <p><input type="checkbox"/> Allergy shots</p> <p align="center"><b>Cardiovascular</b></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Raynaud's</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Leg edema</p>	<p><b>Dermatology</b></p> <p><input type="checkbox"/> New hair loss</p> <p><input type="checkbox"/> New lumps / bumps</p> <p><input type="checkbox"/> Allergy to sun</p> <p><input type="checkbox"/> Color change in cold</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Skin cancer</p> <p align="center"><b>Endocrinology</b></p> <p><input type="checkbox"/> New hormone pills</p> <p><input type="checkbox"/> New thyroid problem</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Polyuria / Frequent urination</p> <p><input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Diabetes</p> <p align="center"><b>ENT</b></p> <p><input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> Cold / Congestion</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus pain</p>	<p><b>Eye</b></p> <p><input type="checkbox"/> Dry eyes</p> <p><input type="checkbox"/> Red eyes</p> <p><input type="checkbox"/> Contacts</p> <p><input type="checkbox"/> Loss of vision</p> <p><input type="checkbox"/> Eye irritation or pain</p> <p><input type="checkbox"/> Eye mattering</p> <p><input type="checkbox"/> Blurring of vision</p> <p align="center"><b>Female Reproductive</b></p> <p><input type="checkbox"/> Vaginal discharge or bleeding</p> <p><input type="checkbox"/> Menstrual irregularity</p> <p><input type="checkbox"/> Risks for sexually transmitted disease/ HIV</p> <p><input type="checkbox"/> Contraception</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Hot flashes</p> <p align="center"><b>Gastroenterology</b></p> <p><input type="checkbox"/> Nausea / Dyspepsia</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Dysphagia</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Blood in stool</p> <p align="center"><b>Hematology/ Lymph</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> More infections than others</p> <p><input type="checkbox"/> Swollen glands</p>	<p><b>Male Reproductive</b></p> <p><input type="checkbox"/> Risk for sexually transmitted disease/ HIV</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Penile discharge</p> <p align="center"><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Back or neck pain</p> <p><input type="checkbox"/> Joint stiffness</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> Bone density done elsewhere</p> <p><input type="checkbox"/> Fracture</p> <p align="center"><b>Neurology</b></p> <p><input type="checkbox"/> Muscle cramps</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> New weakness of arm or leg</p> <p><input type="checkbox"/> New headache</p> <p><input type="checkbox"/> Tingling numbness hands or feet</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Lightheaded/ fainting</p> <p><input type="checkbox"/> Loss of balance/ falls</p>	<p><b>Psychology</b></p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Feeling blue or depressed</p> <p><input type="checkbox"/> High stress level</p> <p><input type="checkbox"/> Difficulty with sleep</p> <p><input type="checkbox"/> Mental or physical abuse</p> <p><input type="checkbox"/> Worries or anxiety</p> <p align="center"><b>Respiratory</b></p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Painful breathing / pleurisy</p> <p><input type="checkbox"/> Cough</p> <p align="center"><b>Urology</b></p> <p><input type="checkbox"/> Painful urinating</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Loss of urinary control</p> <p><input type="checkbox"/> Kidney stone</p> <p><input type="checkbox"/> Urination at night</p>
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**Number of:**

\_\_\_\_Pregnancies

\_\_\_\_Deliveries

\_\_\_\_Miscarriages/abortions

**Ethnic origin**

\_\_\_\_\_

**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	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Circle any you may have taken in the past</b>					
Ansaid (flurbiprofen) Clinoril (sulindac) Feldene (piroxicam) Mobic (Meloxicam) Oruvail (ketoprofen) Arthrotec (diclofenac + misoprostil)	Daypro (oxaprozin) Indocin (indomethacin) Motrin/Rufen (ibuprofen) Tolectin (tolmetin) Aspirin (including coated aspirin) Disalcid (salsalate)	Lodine (etodolac) Nalfon (fenoprofen) Trilisate (choline magnesium trisalicylate) Celebrex (celecoxib) Dolobid (diflunisal)	Meclomen (meclofenamate) Naprosyn (naproxen) Vimovo (naproxen/esomeprazole) Voltaren (diclofenac)		
<b>Pain relievers</b>					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine/Hydrocodone (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tramadol (Ultram or Ultracet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Arava (Leflunomide)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatex)		<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"/>	
Cellcept		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cimzia		<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"/>	
Humira (Adalimumab)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kineret (Anakinra)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituxan (Rituxinab)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orencia (Abatacept)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Simponi		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Benlysta		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actemra		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Osteoporosis medications</b>					
Prolia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin nasal spray (Miacalcin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Estrogen (Premarin etc )		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ibandronate (Boniva)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teriparatide (Forteo)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Zoledronic Acid (Reclast)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gout medications</b>					
Krystexxa		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine (Colcrys)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uloric		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Others</b>					
Breast cancer medication		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glucosamine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc/Euflexxa/Orthovisc/Supartz		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or nutritional supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Please list supplements:</b>					

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ ACN Physician Initials \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING**

I live in a (circle one):      Home                      Town home                      Apartment                      Assisted 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? \_\_\_\_\_

**Please try to answer all of the following questions, answer exactly as you think or feel. There are no right or wrong answers. Check the one best answer for each question.**

<b>AT THIS MOMENT, are you able to:</b>	Without <b>ANY</b> difficulty	With <b>SOME</b> difficulty	With <b>MUCH</b> difficulty	<b>UNABLE</b> to do
Dress yourself, including tying shoelaces, doing buttons?	0	1	2	3
Get in and out of bed?	0	1	2	3
Lift a full cup or glass to your mouth?	0	1	2	3
Walk outdoors on flat ground?	0	1	2	3
Wash and dry your entire body?	0	1	2	3
Bend down to pick up something from the floor?	0	1	2	3
Turn regular faucets on and off?	0	1	2	3
Get in and out of a car, bus, train or airplane?	0	1	2	3
Walk two miles?	0	1	2	3
Participate in sports and games as you like?	0	1	2	3
Get a good night's sleep?	0	1.1	2.2	3.3
Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

<b>1=0.33</b>	<b>2=0.67</b>
<b>3=1.0</b>	<b>4=1.33</b>
<b>5=1.67</b>	<b>6=2.0</b>
<b>7=2.33</b>	<b>8=2.67</b>
<b>9=3.0</b>	<b>10=3.33</b>
<b>11=3.67</b>	<b>12=4.0</b>
<b>13=4.33</b>	<b>14=4.67</b>
<b>15=5.0</b>	<b>16=5.33</b>
<b>17=5.67</b>	<b>18=6.0</b>
<b>19=6.33</b>	<b>20=6.67</b>
<b>21=7.0</b>	<b>22=7.33</b>
<b>23=7.67</b>	<b>24=8.0</b>
<b>25=8.33</b>	<b>26=8.67</b>
<b>27=9.0</b>	<b>28=9.33</b>
<b>29=9.67</b>	<b>30=10.0</b>

**HAQ SCORE =**

How much pain have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been (0=No pain; 10=Worst Pain)

\_\_\_\_\_ Pain Score

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0	

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing?

(0=Very well; 10=Very Poorly)

\_\_\_\_\_ Global Score

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0	

**Rapid 3(0-30)**

Cat: \_\_\_\_\_

HS=>12 \_\_\_\_\_

MS=6.1-12 \_\_\_\_\_

LS=3.1-6 \_\_\_\_\_

R=<3 \_\_\_\_\_

After you wake up, how long does it take you to limber up?      AM stiffness: \_\_\_\_\_ (min or hours)

What is the hardest thing for you to do? \_\_\_\_\_

Are you receiving disability? ..... Yes                       No

Are you applying for disability? ..... Yes                       No

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



# ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD

Alan J. Jacobs, MD

Rick C. Chatwell, MD

Robert M. Valente, MD

Anne R. Lorenz, APRN

Kristina A. Tyndall, APRN

*Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation*

Date \_\_\_\_\_

## PLEASE NOTE

**We are requesting the following information in order to better serve you and to ensure the proper routing of medical reports. Please complete the following using BLACK or BLUE INK:**

\*It is **very important** the doctor's first and last name be listed along with the city and state.

**Patient Full Name** (please print): \_\_\_\_\_

City, State (please print): \_\_\_\_\_, \_\_\_\_\_

**Family Physician:** \_\_\_\_\_  
(First Name) (Last Name) (MD, PA, NP)

City, State (please print): \_\_\_\_\_, \_\_\_\_\_

**\*If PA (Physician Assistant) - which Doctor does he/she practice under?**

\_\_\_\_\_

### **Pharmacy Preferences:**

#### **Local Pharmacy**

\_\_\_\_\_  
(Name) (Address-Example: 56<sup>th</sup> & Highway 2 ) (Phone #)

#### **Mail Order Pharmacy**

\_\_\_\_\_  
(Name) (Address) (Phone #)

**Thank you for taking the time to provide this information to our office.**



**Patient Name:** \_\_\_\_\_

**Account #:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND CONSENT TO OBTAIN HEALTH INFORMATION**

**I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM**

- I hereby authorize photocopies of the Patient Information Form to be valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing.
- I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pending of insurance processing.
- I hereby authorize the Arthritis Center of Nebraska Providers to view the external prescription history via the RxHub service for the patient listed above.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years

\_\_\_\_\_ **X** \_\_\_\_\_  
Date Patient's or authorized person's signature

**X** \_\_\_\_\_  
Relationship to patient, if not the patient

**ACKNOWLEDGEMENT**

**PLEASE CHECK ONE AND SIGN:**

I acknowledge that I am aware of **Notice of Privacy Act Practices** and decline to be given a copy of the document: \_\_\_\_\_

I request to be given a copy of the **Arthritis Center of Nebraska's Notice of Privacy Practices** document: \_\_\_\_\_

\_\_\_\_\_ **X** \_\_\_\_\_  
Date Patient's or authorized person's signature



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**Patient Name** \_\_\_\_\_ **Account #:** \_\_\_\_\_

**RELEASE OF MEDICAL AND BILLING INFORMATION  
(Complete this form if you wish to allow family or others access to  
your medical and billing information)**

I, \_\_\_\_\_ do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance or other account information to the family member(s)/parties listed below:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**X Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note: This form is valid from the date signed until another form is requested by the patient.**

X: MedRecords/Release of Med and Billing Info