

# Patient History Form

Advanced Directive Care Plan?  Yes  No

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 (\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_) \_\_\_\_\_

**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  Internet  Health fair  Radio  Arthritis lecture  Other

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

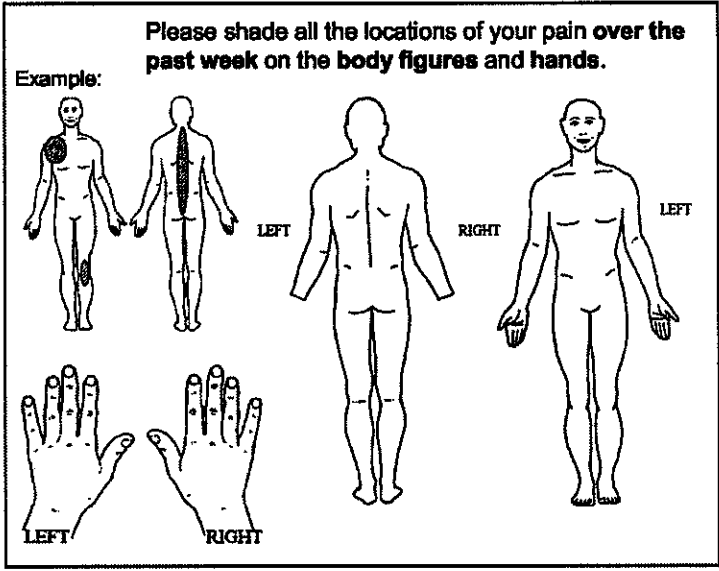
Name of person making referral: \_\_\_\_\_

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")

Yourselves	Relative Name/Relationship	Yourselves	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** (Please write down all your medications even if you bring them with you to your appointment. Include such items as over the counter pain medications i.e. Tylenol, ibuprofen, aspirin, along with any 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"/> Anxiety and/or Depression                           |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Colitis            | <input type="checkbox"/> Sleep apnea   |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Asthma  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach ulcers     | <input type="checkbox"/> Emphysema   |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Pneumonia (Hospitalized)                            |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Kidney Disease                                      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Clotting Disorders (Blood Clot, Lung Clots, Stroke) |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Severe headaches   |  |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Seizure Disorder   |  |

Natural or alternative therapies (chiropractic, accupuncture, 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 vape? \_\_\_\_\_  
 Do you use street/recreational drugs?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Did you have a drink containing alcohol in the past year?  Yes  No  
 If 'Yes': How often did you have a drink containing alcohol in the past year?  
 Never  Monthly or less  2 to 4 times a month  
 2 to 3 times per week  4 or more times a week  
 If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year? \_\_\_\_\_  
 If 'Yes': How often did you have six or more drinks on one occasion in the past year?  
 Never  Less than monthly  Monthly  
 Weekly  Daily or almost daily

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 surgeries**

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 brothers living \_\_\_\_\_ Number of brothers deceased \_\_\_\_\_ / cause of death \_\_\_\_\_  
 Number of sisters living \_\_\_\_\_ Number of sisters deceased \_\_\_\_\_ / cause of death \_\_\_\_\_  
 Number of sons living \_\_\_\_\_ Number of sons deceased \_\_\_\_\_ / cause of death \_\_\_\_\_ Ages of each \_\_\_\_\_  
 Number of daughters living \_\_\_\_\_ Number of daughters deceased \_\_\_\_\_ / cause of death \_\_\_\_\_ Ages of each \_\_\_\_\_  
 Health of children: \_\_\_\_\_

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

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

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

**SYSTEMS REVIEW**

Mammogram  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Eye Exam  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Chest X-ray  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Tuberculosis Test  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Bone Densitometry  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Influenza (Flu) Vaccination  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Pneumonia Vaccination  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Tetanus (DTaP)  No  Yes \_\_\_\_/\_\_\_\_  
MONTH YEAR

Shingles Vaccination  No  Yes Dose 1 \_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_  
MONTH YEAR MONTH YEAR

COVID Vaccination  No  Yes Dose 1 \_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_ Last Booster \_\_\_\_/\_\_\_\_  
MONTH YEAR MONTH YEAR MONTH YEAR

Evusheld \_\_\_\_/\_\_\_\_  
MONTH YEAR

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"/> Change in weight</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Fatigue</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Chest pain</p>	<p><b>Dermatology</b></p> <p><input type="checkbox"/> New hair loss</p> <p><input type="checkbox"/> Allergy to sun</p> <p><input type="checkbox"/> Finger 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><b>Endocrinology</b></p> <p><input type="checkbox"/> New thyroid problem</p> <p><input type="checkbox"/> Excessive thirst</p> <p><b>ENT</b></p> <p><input type="checkbox"/> Dry eyes</p> <p><input type="checkbox"/> Dry mouth</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Mouth sores</p>	<p><b>Eye</b></p> <p><input type="checkbox"/> Eye redness &amp; pain</p> <p><input type="checkbox"/> Loss of vision</p> <p><b>Female Reproductive</b></p> <p><input type="checkbox"/> Contraception</p> <p><input type="checkbox"/> Menopause</p> <p><b>Gastroenterology</b></p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Blood in stool</p>	<p><b>Male Reproductive</b></p> <p><input type="checkbox"/> Penile discharge</p> <p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Legs cramps</p> <p><input type="checkbox"/> Fracture</p> <p><b>Neurology</b></p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> New headache</p> <p><input type="checkbox"/> Tingling numbness hands</p> <p><input type="checkbox"/> Tingling numbness feet</p> <p><input type="checkbox"/> Loss of balance/falls</p>	<p><b>Psychology</b></p> <p><input type="checkbox"/> Feeling blue or depressed</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><b>Respiratory</b></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><b>Urology</b></p> <p><input type="checkbox"/> Blood in urine</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							
Disease Modifying Antirheumatic Drugs (DMARDs)	Please check: Helped?			Non-Steroidal Pain Relievers	Please check: Helped?		
	A lot	Some	Not at all		A lot	Some	Not at all
Abatacept (Orencia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin (including coated aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adalimumab (Humira)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Celecoxib (Celebrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adalimumab Atto (Amjevita)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choline magnesium trisalicylate (Trilisate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anifralumab (Saphnelo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diclofenac (Voltaren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apremilast (Otezla)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diclofenac + Misoprostil (Arthrotec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azathioprine (Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disalcid (Salsalate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baricitinib (Olumiant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diffunisal (Dolobid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belimumab (Benlysta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Etodolac (Lodine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Certolizumab (Cimzia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fenoprofen (Nalfon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide (Cytosan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flurbiprofen (Ansaid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclosporine / Tacrolimus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen (Motrin / Advil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etanercept (Enbrel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indomethacin (Indocin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Golimumab (Simponi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ketoprofen (Oruvail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydroxychloroquine (Plaquenil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meclofenamate (Meclomen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infliximab (Remicade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meloxicam (Mobic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ixekizumab (Taltz)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nabumetone (Relafen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (Arava)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Naproxen (Naprosyn / Aleve)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Rheumatrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Naproxen/Esomeprazole (Vimovo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mycophenolate mofetil (CellCept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxaprozin (Daypro)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risankizumab (Skyrizi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Piroxicam (Feldene)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituximab (Rituxan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulindac (Clinoril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sarilumab (Kevzara)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tolectin (Tolmetin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secukinumab (Cosentyx)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other pain relievers</b>			
Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tocilizumab (Actemra)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine/Hydrocodone (Vicodin, Tylenol 3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tofacitinib (Xeljanz)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upadacitinib (Rinvoq)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxycontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tramadol (Ultram or Ultracet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Osteoporosis medications</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abaloparatide (Tymlos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Others</b>				Alendronate / Fosamax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Denosumab (Prolia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucosamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Estrogen (Premarin, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbal or nutritional supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ibandronate (Boniva)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gout medications</b>				Raloxifene (Evista)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allopurinol (Zyloprim/Lopurin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Risedronate (Actonel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colchicine (Colcrys)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Romosozumab (Evenity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Febuxostat (Uloric)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teriparatide (Forteo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Probenecid (Benemid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Zoledronic Acid (Reclast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please list supplements:</b>							

**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
Vacuum the house and do necessary yardwork?	0	1	2	3
Run errands and shop as you would 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>
<b>HAQ SCORE =</b>	

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"/>
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? \_\_\_\_\_ Global Score  
(0=Very well; 10=Very Poorly)

<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

<b>Rapid 3(0-30)</b>
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  
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 print in black ink)*

Co. Name \_\_\_\_\_

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

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

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

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

Address \_\_\_\_\_

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

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

\*\*\*\*\*

Co. Name \_\_\_\_\_

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

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

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

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

Address \_\_\_\_\_

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

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

\*\*\*\*\*

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 (Insured)** Name \_\_\_\_\_

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*



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. **PRIOR AUTHORIZATION/REFERRAL FOR INSURANCE**

I understand that it is my responsibility to obtain prior authorization and/or physician referrals if required by 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 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, procedures and tests (including testing for HIV (AIDS) and Hepatitis, if ordered by provider) 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 (if not the Patient, relationship to the patient) \_\_\_\_\_

2. **RELEASE OF MEDICAL AND BILLING INFORMATION**

(Complete this section of 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 \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

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

Patient's or authorized person's signature Date

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

3. **I AUTHORIZE THAT VOICE MESSAGES MAY BE LEFT ON MY PHONE(S)**  Yes  No

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

Patient's or authorized person's signature Date

4. **ACKNOWLEDGEMENT - PLEASE CHECK ONE AND SIGN:**

- I acknowledge that I am aware of Notice of Privacy Act Practices (2/2026) & 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 (2/2026)

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

Patient's or authorized person's signature Date

<b>Office Use Only:</b> Copy given to patient _____	_____	_____	_____
	Staff Initials	Date	Account Number



# ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD  
William J. Saalfeld, DNP

Mashood Badshah MD  
Karis A. Lange, PA-C  
Kaila M. Steinkuhler, PA-C

Kristin A. Twidwell, PA-C  
Samone M. Wulf, PA-C

*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): \_\_\_\_\_, \_\_\_\_\_

DOB: \_\_\_\_\_

**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.**



Melvin A. Churchill, MD  
Mashood Badshah, MD  
Kristin A. Twidwell, PA-C  
William J. Saalfeld, DNP  
Karis A. Lange, PA-C  
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Kaila M. Steinkuhler, PA-C

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

### **IMPORTANT NOTICE ABOUT YOUR INSURANCE AND PAYMENT POLICY**

Please bring your insurance card(s) to your appointment.

**\*\*If not available at time of appointment, you will be rescheduled.**

**If you have a change of insurance it is your responsibility to notify us.**

❖ Medicare replacement plans (Medicare Advantage plans) – Please contact your insurance carrier to verify participation.

❖ **If you do not live in Nebraska** – Please contact your insurance carrier for participation status of the plans below.

**We are participating providers (In network\*) with the following insurance plans:**

- Medicare Part B
- Blue Shield
- Coventry
- First Health
- Interplan Health Group/Accountable Health
- Midlands Choice
- Nebraska Medicaid Health Plans
- United HealthCare

\*It is your responsibility to check with your insurance regarding participating (In network) status.

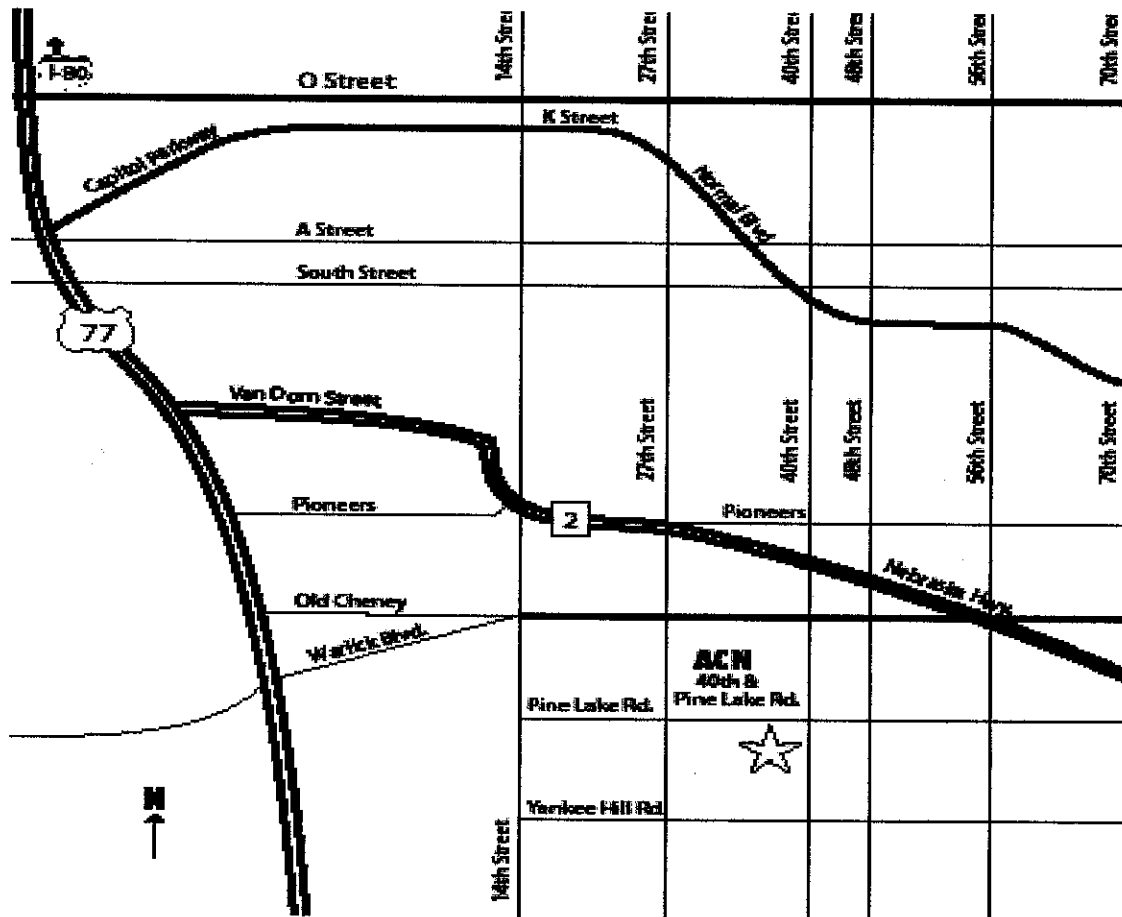
**NOTE: We do not participate with United HealthCare Military & Veterans (Formally Tricare West Region), ChampVa or Tricare For Life - however we will file your claim and accept assignment. They will pay us directly and our office will do the appropriate adjustment and bill you for any balance.**

### **IMPORTANT INFORMATION REGARDING BILLING**

- ∞ **Copays if applicable** – payment required at the time of your appointment.
- ∞ **Coinsurance or Deductible balance** – we will bill you when your insurance company processes your claim. You then have 30 days to pay this balance.

**If you are unable to pay your balance within 30 days of receiving your 1<sup>st</sup> statement please call the Business Office at (402) 420-3400 to make payment arrangements.**

Business Office Hours 7:00am-5:00pm M-Th & 7:00am-4:00pm Friday



Arthritis Center of Nebraska  
 Located in the Bryan Health Pine Lake Medical Plaza  
 (Southwest Corner of the Intersection of 40<sup>th</sup> and Pine Lake Road)  
 3901 Pine Lake Road Suite 120  
 Lincoln, NE 68516  
 402-420-1212  
 Toll Free 1-855-882-5310

Enter the main lobby on the west side of the building, turn  
 right, and proceed straight ahead to our office

**\*If coming from the west on I-80** take Exit 397 (Hwy 77 bypass towards Beatrice) and go south to Old Cheney Rd. Turn left and go east on Old Cheney to 40<sup>th</sup> Street. Turn right onto 40<sup>th</sup> and go south to Pine Lake Rd. Cross Pine Lake Road – take first driveway on right – drive around to the main entrance on the west side of the building.

**\*If coming from the east on Hwy 2** – Take Hwy 2 to 40<sup>th</sup> Street. Turn left onto 40<sup>th</sup> and go South to Pine Lake Road (approximately 1 ½ miles). Cross Pine Lake Road – take first driveway on right – drive around to the main entrance on the west side of the building.