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5414 FREDERICKSBURG RD STE. 150 SAN ANTONIO, TX 78229 PHONE: (210) 615-9800, FAX: (210) 615-9801. www.happyjointmd.com

Dear Patient,

Thank you for choosing South Texas Arthritis Care Center for addressing your rheumatologic condition.

In order to better serve you, I have enclosed a New Patient History Form for you to fill out. Please fill this form out completely before your scheduled visit, as it may take some time to fill out. As a reminder, please bring the following documents filled out **completely** on your scheduled appointment (please do not mail):

1. Proof of Insurance
2. Office Policies-Please sign at the bottom and place you initials by each number
3. Patient Demographic Information Form
4. New Patient History Form
5. Authorization to Release Medical Records, signed. This enables us to obtain any records we need from your doctors.
6. Referral note or letter from the doctor who requested a rheumatology consultation, indicating the reason you were referred. If you have an **HMO**, please read yellow sheet.
7. Any information, such as medical records, lab work, x-rays, CT scan or MRI readings, that will be helpful for me to better evaluate your case.

Please arrive **30 minutes before your scheduled appointment** in order to be processed into our system. If you are not here at the requested time before your appointment, we may have to delay or reschedule your visit.

IMPORTANT:
Please confirm your appointment at least one day before. We will remind you of your appointment 2 days prior to your visit. **If we do not hear from you or cannot reach you, your appointment will be cancelled in order to accommodate other patients who need to be seen.**

Our office hours are: **7:40 am to 4:30 pm, Monday to Thursday**
7:30 am to 1:00 pm, Friday

We strive to make your experience at South Texas Arthritis Care Center a pleasurable one.
If you have any questions, please feel free to call. I'm looking forward to meeting you.

Sincerely,

Emily R. Pineda, MD
«RendPrFName» «RendPrLName»

OFFICE POLICIES

Welcome to South Texas Arthritis Care Center. We appreciate the opportunity to work with you. In order to serve you better, we have implemented the following office policies. Please initial to signify that you have read, understood and will comply with the policies. Thank you.

<u>Please initial by each number</u>:

_______1. **PAYMENTS**. All applicable fees, deductibles, coinsurance or copays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard or Discover. There will be a will be a $25.00 charge for all returned checks. Patients who present checks which are dishonored will be required to pay future amounts due with cash, money orders, or credit cards.

_______2. **CANCELLATIONS**. If you need to cancel and reschedule your appointment, please be sure to call us at least 24 hours before your scheduled appointment. You will be charged for the visit for late cancellations or missed appointments, unless you had an emergency.

_______3. **HMO & PPO REFERRALS**. If your policy requires written authorization (referrals or precertification) from your primary care physician or PCP, we required that we have is authorization on file in our office before your scheduled appointment. It is your responsibility to make sure that your visit is pre-approved so that your insurance company will pay for your visit. Otherwise you will be responsible for the payment in full.

________4. **OFFICE COURTESY**. Please do not bring any food or drinks into the clinic. Childcare is not provided for children. Please do not leave children unattended in the reception area.

________5. **MEDICATION REFILL REQUEST**. We will only approve a medication refill request after business hours or on weekends if it is a true emergency; and there will be a charge for this service. Therefore, it is important for you to have your doctor write your prescriptions at the time of your visit.

________6. **LAB TEST RESULTS**. Because of telephone limitations, we ask that you not call us to check on lab results. We will call you to report any significantly abnormal results.

________7. **ANSWERING SERVICE**. A 24-hour answering service is available for emergency situations by calling our main number the 210 615-9800.

"I, the guarantor of payment and responsible party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature of Patient:____ Date:_____________________________

Printed Name: ____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________, have read the **South Texas Arthritis Care Center's** Notice of Privacy Practices.
(Print Name)

Signature of Patient:____ Date:_____________________________

SOUTH TEXAS ARTHRITIS CARE CENTER

PATIENT DEMOGRAPHIC INFORMATION

Title:________Name:____Suffix:____
(First) (M.I.) (Last)

SS#:__________ __-__________-________________ DOB:________________________ Age:___________

Address____
(No.) (Street) (Apt #)

____
(City) (State) (Zip code)

Gender:

Marital Status
Single Married
Divorced Separated

Home phone:________________Work phone:__________________ Cell phone:________________________

Emergency ontact:___________________________Relationship:_____________Phone:_________________

Primary Care Physician (PCP):__________________________Referring Physician:______________________

Address of PCP:____Phone no. of PCP:____________________

INSURANCE INFORMATION
(Please list all insurances)

PRIMARY INSURANCE:____Phone no______________________
Policy#_______________Grp#______________Subscriber ID#_______________Effective Date ________________
Policy Holder's Name____DOB______________________
Insured Party SS#___________________________Patient Relationship to Policy Holder______________________
Plan Type: HMO PPO Medicare Medicaid Other____
Referral required: Yes No Co-payment______________________Deductible_________________________
Requirements for referrals & other services____

SECONDARY INSURANCE:___________________________________ ___Phone no______________________
Policy#_______________Grp#______________SubscriberID#_______________Effective Date ________________
Policy Holder's Name____DOB______________________
Insured Party SS#___________________________Patient Relationship to Policy Holder______________________
Plan Type: HMO PPO Medicare Medicaid Other____
Referral required: Yes No Co-payment______________________Deductible_________________________
Requirements for referrals & other services____

TERTIARY INSURANCE:___________________________________ _____Phone no______________________
Policy#_______________Grp#______________Subscriber ID#_______________Effective Date ________________
Policy Holder's Name____DOB______________________
Insured Party SS#___________________________Patient Relationship to Policy Holder______________________
Plan Type: HMO PPO Medicare Medicaid Other____
Referral required: Yes No Co-payment______________________Deductible_________________________
Requirements for referrals & other services____

By signing this statement, I hereby authorize the release of my medical information to my insurance carriers if requested. I also authorize my insurance companies to pay medical benefits to South Texas Arthritis Care Center for medical services rendered.

Signature of Patient or Responsible Party____________________________________**Date**__________________

Patient HMO Referral Notice

It is the patient's responsibility to contact their primary care physician **(PCP)** to request a referral to be generated for services to be rendered at South Texas Arthritis Care Center.

You can either bring the referral with you or have your **PCP** fax the referral prior to her appointment date to
201-615-9801. If we do not have the referral on the day of her appointment, we will have to reschedule your appointment.

Thank you.

NEW PATIENT HISTORY FORM

Name: ____
Last First M.I.

Address:______________________________________ Age:________ Date of Birth:____________________
Street Apt. # Sex: □ F □ M Birthplace:____________________

____ Phone:Home: ________-_________-__________
City State Zip Work: ________-_________-__________
Email address:_________________________ Pharmacy#: _____-_____-_______ Cell: ________-_________-__________

Referred here by: (check one): ❑Self ❑Family ❑Friend ❑Doctor ❑Other Health Professional

Name of person making referral:____

Name of physician providing your primary medical care(PCP):____

Address of Primary care provider (PCP):______________________________Phone of PCP:________________

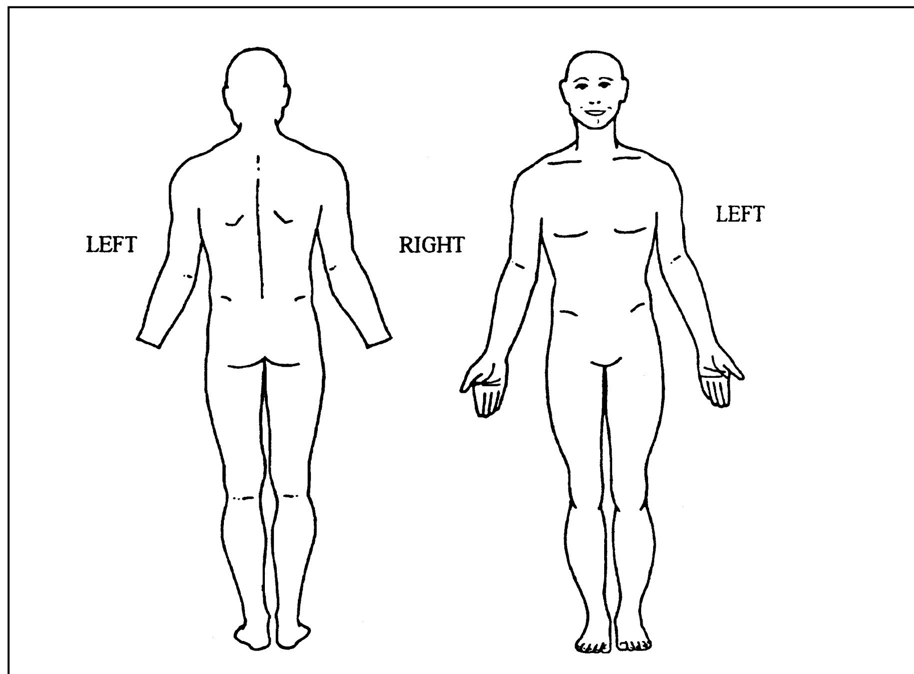
Other Physicians you are seeing and their Specialties:____

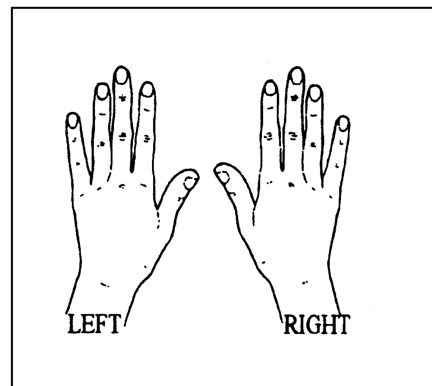
____

Reason you were referred:____

____

Please shade all the locations of your pain over the past week:





PATIENT: ______________________________, DATE OF BIRTH: ___________ APPOINTMENT DATE: ____________

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What joint or muscle group causes the most pain?____

Describe quality of pain (e.g. aching, burning, sharp, dull):____

How long has your pain been present?____

Does the pain occur on and off or continuously?____

Time of day your pain is worse? ❑ Morning ❑ End of day

Is your symptom associated with joint stiffness in the morning? ❑Yes ❑ No. How long?_______minutes________hours

What makes you pain worse?____

____

What relieves/improves your pain?____

____

What worsens your pain? ❑ Mild Activity ❑ Inactivity ❑Overactivity ❑Rest ❑ Work.

If your work makes your pain worse, what type of work do you do?_______________________________________

What type of activity at work makes your pain worse? ____

____

Previous treatment for this problem (include physical therapy, specific surgery, injections and names of medication tried)

and mention if it helped or not:____

____

____

Please list practitioners/doctors you have seen for this problem:_____________________________________

____

____

If there is anything else you would like to add regarding the problem you came to our office today, please write below:

____

____

____

____

____

____

____

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SOUTH TEXAS ARTHRITIS CARE CENTER

SYSTEMS REVIEW

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

Date of last Tuberculosis Test ____________ Date of last bone densitometry ____________ Date of last chest x–ray ____________

Are you receiving disability? ❑Yes ❑No Are you applying for disability? ❑Yes ❑No

Do you have a medical related lawsuit pending? ❑Yes ❑No

Constitutional
- ❑ Recent weight gain
  amount ____________
- ❑ Recent weight loss
  amount ____________
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

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

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? ____________

Musculoskeletal
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in the last 6 mos.

____
____
____
____
____

Integumentary (skin and/or breast)
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

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

Endocrine
- ❑ Excessive thirst

Hematologic/Lymphatic
- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Blood clot
- ❑ Transfusion/when ____________

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

PAST MEDICAL HISTORY
Do you now or ever had: (check if yes)

- ❑ Cancer,type:
- ❑ Goiter
- ❑ Cataracts
- ❑ Nervous breakdown
- ❑ Migraine headaches
- ❑ Kidney disease
- ❑ ↑Blood Pressure
- ❑ Emphysema
- ❑ Reflux (GERD)
- ❑ Fibromyalgia
- ❑ Osteoarthritis
- ❑ Cholesterol problem
- ❑ Heart problems
- ❑ Leukemia
- ❑ Diabetes
- ❑ Stomach ulcers
- ❑ Jaundice
- ❑ Pneumonia
- ❑ HIV/AIDS
- ❑ Glaucoma
- ❑ Arthritis-type unknown
- ❑ Rheumatoid arthritis
- ❑ Gout
- ❑ Depression
- ❑ Asthma
- ❑ Stroke
- ❑ Epilepsy
- ❑ Rheumatic fever
- ❑ Bowel Inflammation
- ❑ Psoriasis
- ❑ Anemia
- ❑ Tuberculosis
- ❑ Hypothyroidism
- ❑ Lupus
- ❑ Osteoporosis

Other medical problems:____

____

SOCIAL HISTORY

Do you smoke? ❑ No. Never
❑ Past.. How long ago?_________________
❑ Yes. Packs per day: ___________________

Do you drink alcohol? ❑ Yes ❑ No. # per week ____________
Has anyone ever told you to cut back on alcohol?___________
Do you use drugs for non-medical reasons?________________
If yes, please list:_____________________________________
Do you exercise regularly?_________Type________________

Marital Status: ❑Never Married ❑Married ❑ Divorced ❑ Separated ❑ Widowed

# of pregnancies:____________ # of children______________

# of miscarriages:______ At what month of pregnancy?_______

Occupation:____

Employer:____

If retired, Former Occupation: __________________________

Spouse's occupation:_________________________________

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:____

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

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.			❑	❑	❑

ALLERGIES to medication:____
What was your reaction?____

SOUTH TEXAS ARTHRITIS CARE CENTER

FAMILY HISTORY

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

Health of children: ______________________________

____

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

- ❑ Cancer ____________
- ❑ Heart disease ____________
- ❑ Rheumatic fever____________
- ❑ Tuberculosis ____________
- ❑ Leukemia ____________
- ❑ High blood pressure ____________
- ❑ Epilepsy____________
- ❑ Diabetes ____________
- ❑ Stroke ____________
- ❑ Bleeding tendency ____________
- ❑ Asthma ____________
- ❑ Goiter ____________
- ❑ Colitis ____________
- ❑ Alcoholism____________
- ❑ Psoriasis ____________
- ❑ Underactive thyroid____________
- ❑ Arthritis(unknown type) ____________
- ❑ Osteoarthritis____________
- ❑ Lupus____________
- ❑ Osteoporosis____________
- ❑ Rheumatoid arthritis____________
- ❑ Gout____________
- ❑ Ankylosing Spondylitis____________

❑ Other significant Family History (please list)______________________________

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? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs-NSAIDs		❑	❑	❑	

Circle any you have taken in the past

Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac)

Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac)

Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen)

Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)

Drug names/Dosage	Length of time	A Lot	Some	Not At All	Reactions
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	

Disease Modifying Antirheumatic Drugs (DMARDS)

Leflunamide (Arava)		❑	❑	❑	
Mycophenolate mofetil (Cellcept)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Adalimumab (Humira)		❑	❑	❑	
Rituximab (Rituxan)		❑	❑	❑	
Abetacept (Orencia)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Ibandronate (Boniva)		❑	❑	❑	
Parathyroid hormone (Forteo)		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc/Supartz/Euflexxa injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

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

If yes, list: ______________________________

____

____

____

PATIENT: ______________________________, DATE OF BIRTH: _________APPOINTMENT DATE: __________

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HEALTH ASSESSMENT QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS WITHIN A WEEK OR ON THE DAY OF YOUR VISIT.
This questionnaire is designed to help us assess how your illness affects your ability to function in daily life.
Thank you.

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

NO PAIN O O O O O O O O O O O O O O O O O O O O O PAIN AS BAD AS CAN BE
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

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

VERY WELL O O O O O O O O O O O O O O O O O O O O O VERY POORLY
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

3. How much of a problem has unusual fatigue or tiredness been for you OVER THE PAST WEEK?

NO FATIGUE O O O O O O O O O O O O O O O O O O O O O FATIGUE MAJOR PROBLEM
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

4. **Please check (√) the ONE best answer for your abilities at this time (MD-HAQ)**:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** DIfficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	____0	____1	____2	____3
b. Get in and out of bed?	____0	____1	____2	____3
c. Lift a full cup or glass to your mouth?	____0	____1	____2	____3
d. Walk outdoors on flat ground?	____0	____1	____2	____3
e. Wash and dry your entire body?	____0	____1	____2	____3
f. Bend down to pick up clothing from the floor?	____0	____1	____2	____3
g. Turn regular faucets on and off?	____0	____1	____2	____3
h. Get in and out of the car, bus, train, or airplane?	____0	____1	____2	____3
i. Walk 2 miles or three kilometers, if you wish?	____0	____1	____2	____3
j. Participate in recreational activities and sports as you would like, if you wish?	____0	____1	____2	____3
k. Get a good night's sleep?	____0	____1.1	____2.2	____3.3
l. Deal with feelings of anxiety or being nervous?	____0	____1.1	____2.2	____3.3
m. Deal with feelings of depression or feeling blue?	____0	____1.1	____2.2	____3.3

FOR OFFICE USE ONLY

1. PAIN (0-10)

2. PTGL (0-10)

3. FTG (0-10)

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.1
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

4. MD-HAQ: a-j (0-10)

5. PSY: k-j (0-9.9)

PATIENT: ____________________________, DATE OF BIRTH: _________ APPOINTMENT DATE: _____________

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