Arthritis & Rheumatology Associates of SJ, P.C.

2848 S. Delsea Drive, Ste 2C, Vineland, NJ 08360
Phone (856) 794-9090 Fax (856) 794-3058

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST FIRST MIDDLE INITIAL MAIDEN) Birthdate: ____/____/____ (MONTH DAY YEAR)

Address: _____ (STREET APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY STATE ZIP) Telephone: Home (____) _____ Work (____) _____

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

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses _____

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 _____

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

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

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

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

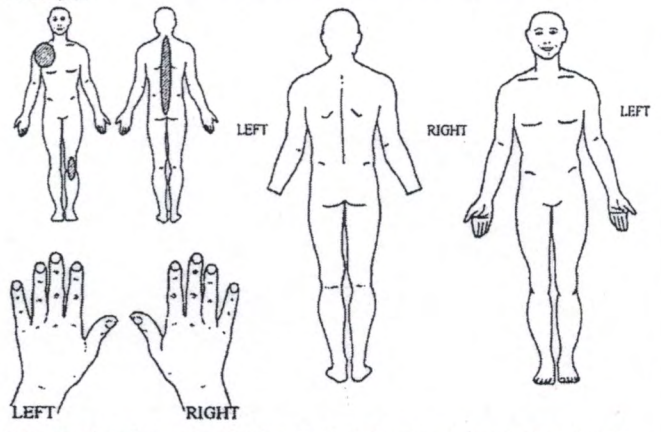
_____

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

_____

_____

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



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

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

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SYSTEMS REVIEW

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

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 ____/____/____

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

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ 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
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

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SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago?_____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week_____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

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

❑ Cancer	❑ Heart problems	❑ Asthma
❑ Goiter	❑ Leukemia	❑ Stroke
❑ Cataracts	❑ Diabetes	❑ Epilepsy
❑ Nervous breakdown	❑ Stomach ulcers	❑ Rheumatic fever
❑ Bad headaches	❑ Jaundice	❑ Colitis
❑ Kidney disease	❑ Pneumonia	❑ Psoriasis
❑ Anemia	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

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:_____

FAMILY HISTORY:

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

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

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 _____	

Patient's Name _____ Date _____ Physician Initials _____

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MEDICATIONS

Drug allergies: ☐ No ☐ Yes If yes, please list: _____

_____

Type of reaction: _____

PRESENT MEDICATIONS *(List any medications you are taking. Include items such 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	Helped a lot	Helped some	Helped not at all
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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.*

Drug names/Dose	Length of time	Helped a lot	Helped some	Helped not at all	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Flurbiprofen					
Diclofenac + misoprostill					
Aspirin (including coated aspirin)					
Celecoxib					
Sulindac					
Oxaprozin					
Salsalate					
Diflunisal					
Piroxicam					
Indomethacin					
Etodolac					
Meclofenamate					
Ibuprofen					
Fenoprofen					
Naproxen					
Ketoprofen					
Tolmetin					
Cholinemagnesium trisalcylate					
Diclofenac					

Drug names/Dose	Length of time	Helped A lot	Helped Some	Helped Not At All	Reactions
Pain Relievers					
Acetaminophen					
Codeine					
Propoxyphene					
Biologic DMARDs					
B Cell					
Rituxan (rituximab)					
BLYS					
Benlysta (belimumab)					
Calcineurin Inhibitor					
Lupkynis (voclosporin)					
CTLA4					
Orencia (abatacept)					
IL1					
Kineret (anakinra)					
IL1B					
Ilaris (canakinumab)					
IL6					
Kevzara (sarilumab)					
Actemra (tocilizumab)					
IL 12/23					
Stelara (ustekinumab)					
IL17					
Taltz (ixekizumab)					
Cosentyx (secukinumab)					
IL23					
Tremfya (guselkumab)					
TNF					
Renflexis (infliximab)					
Remicade (infliximab)					
Inflectra (infliximab)					
Humira (adalimumab)					
Cimzia (certolizumab)					
Enbrel (etanercept)					
Ereizi (etanercept -szzs)					
Simponi Aria (golimumab)					
DMARDs					
Imuran (azathioprine)					
Cytoxan (cyclophosphamide)					
Neoral (cyclosporine)					
Plaquenil (hydroxychloroquine)					

Drug names/Dose	Length of time	Helped A lot	Helped Some	Helped Not At All	Reactions
Arava (leflunomide)					
Rheumatrex (methotrexate)					
Cellcept (mycophenolate mofetil)					
Azulfidine (sulfasalazine)					
Xeljanz (tofacitinib)					
Jak Inhibitor					
Olumiant (baricitinib)					
Xeljanz (tofacitinib)					
Ofev (nintedanib)					
Jakafi/Jakavi (ruxolitinib)					
Smyraf (peficitinib)					
Rinvoq (upadacitinib)					
Osteoporosis Meds					
Fosamax (alendronate)					
Boniva (Ibandronate)					
Zometa/Reclast (zoledronic acid)					
Evista (raloxifene)					
Prolia (denosumab)					
Atelvia/Actonel (risedronate)					
Forteo (teriparatide)					
Miacalcin (calcitonin injection or nasal)					
Evenity (romosozumab)					
IVIG					
Privigen					
Gammagard					
Gammar - IV					
Gamimune - N					
Iveegam					
Polygam S/D					
Sandoglobulin					
Venoglobulin - I					
Venoglobulin - S					
Carimune - Panglobulin					
Gamunex					
Kiovig					
Gout					
Krystexxa (pegloticase)					
Lupus					
Benlysta (belimumab)					

Please list supplements:

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

If yes, please list

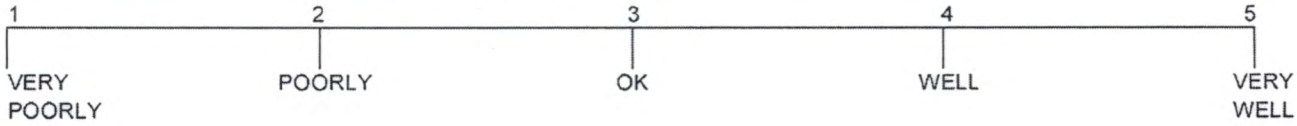
ACTIVITIES OF DAILY LIVING

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? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

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 ❑

Patient's Name _____ Date _____ Physician Initials _____

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Arthritis & Rheumatology Associates of South Jersey, P.C
2848 S Delsea Drive, Ste. 2C, Vineland, N.J. 08360
Phone: (856)794-9090 Fax (856) 794-3058

Name: _____ DOB: _____
Phone Number: _____

_____ I acknowledge that I have received a copy of the "Notice of Privacy Practices" & office policies from Arthritis & Rheumatology Associates of South Jersey, P.C.

I hereby grant permission for disclosure of my personal health information to:

1. _____ Relationship_____ Phone #_____
2. _____ Relationship_____ Phone #_____
3. _____ Relationship_____ Phone #_____

Check Choice Below

_____ I hereby give my permission for Arthritis & Rheumatology Associate of South Jersey, P.C staff to leave information on my answering machine/voice mail in reference to appointments & medical instructions.

_____ I refuse disclosure of my personal health information to anyone other than myself

Do you have a Living Will or Advanced Directive: Yes: ____ No: _____

Arthritis & Rheumatology Associates of South Jersey, P.C photographs patients and places the photo inside of the patient's chart. We do this to help to document medical conditions, prevent medical errors and identify theft.
Do you consent to be photographed? Yes: _____ No: _____

Do you have a language, cultural and/ or religious custom which may impact our providers' ability to provide medical care?

What Type: ☐ Language ☐ Cultural Custom ☐ Religious Custom ☐ None

Note: All Co-pays are due at the time of service. A $30 fee may be assessed for "no-show: appointments. All balances are due in 30 days unless special arrangements are made. We do not routinely call for delinquent accounts. Accounts that are greater than 90days past due are sent for collections unless payment arrangements have been made and are current. You will be responsible for any balances due to lack of coverage and pre-existing conditions not covered under your plan.

Patient/Guarantor Signature: _____ Date: _____

Arthritis & Rheumatology Associates of South Jersey, P.C.
2848 S Delsea Dr., Ste 2C, Vineland, N.J. 08360
Phone: 856-794-9090 Fax: 856-794-3058

Last Name _____
First Name _____
Mailing Address _____
_____
City, State, Zip _____
Home Number _____
Work Number _____
Cell Number _____
Email Address _____

Date of Birth _____
Gender: Male _____ Female _____
Marital Status _____
Social Security # _____
Employer Name _____
Title _____
Employment Status _____
(FT, PT, Retired, Unemployed, Disabled)
Student Status (Ft, PT) _____

Name of Pharmacy _____
Pharmacy Number _____
Location of Pharmacy/address _____

Responsible Party

Last name _____
First name _____ MI _____
Date of Birth _____
Social Security Number _____
Gender: Male _____ Female _____
Relationship_____
Home Number _____
Work Number _____
Cell Number _____
Email Address _____

Emergency Contact

Last name _____
First name _____ MI _____
Date of Birth_____
Relationship_____
Address_____
City, State, Zip _____
Home Number _____
Work Number _____
Cell Number _____
Email Address _____

Insurance

Primary Insurance_____
Insurance Address _____
Address_____
City, State, Zip _____
Phone Number _____
Subscriber/Member ID _____
Group Number_____
Copay Amount_____
Insured's Name_____
Insured's SSN_____
Insured's DOB_____
Relationship_____

Secondary Insurance_____
Insurance_____
Address_____
City, State, Zip _____
Phone Number _____
Subscriber/Member ID #_____
Group #_____
Copay Amount_____
Insured's Name_____
Insured's SSN_____
Insured's DOB_____
Relationship_____

Arthritis & Rheumatology Associates of South Jersey
Financial Policy

Your complete understanding of your financial responsibilities is essential. Your insurance is a contract between you, your employer and the insurance company. **We are not part of that contact.**

Appointment Cancellations: Please notify our office of any appointment cancellations at least 24 hours in advance by calling the office or the answering service. We reserve the right to charge you (not your insurance company) for a missed appointment. This is a $35.00 fee (subject to change without prior notice).

Laboratory, Radiology and other diagnostic service bills: Please check with your insurance company to verify what your insurance benefits allow for. The doctor may order these during your visit. These services are billed separately by the laboratory or diagnostic facility that performs these tests and are not covered by payments that you make to us.

Medical Record Fees: There will be a fee for copying medical records, $1.00/page up to $100.00. There also will be an additional fee for postage & search fee of $10.00. You must fill out a medical records request form to obtain a copy of your medical records. Please allow up to 30 days for copying of medical records.

Payment Responsibility: I hereby authorize payment directly to **Arthritis & Rheumatology Associates of South Jersey, P.C.** of the physician's attendance benefits otherwise payable to me but not to exceed the charges as stated. I understand that I am financially responsible to **Arthritis & Rheumatology Associates of South Jersey, P.C.** for the charges not covered by this authorization. I also understand and agree that if my account is delinquent and incurs collections fees or legal fees, I am responsible for payment of those fees as well as the full balance of my account.

I have read and fully understand the financial policy set forth by Arthritis & Rheumatology Associates of South Jersey. I understand and agree to the terms of this policy. I also understand and agree that the terms of this financial policy may be amended by Arthritis & Rheumatology Associates of South Jersey at any time without prior notification to me.

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name of patient or responsible party Date

_____ _____

Signature of ARASJ Employee Date

Arthritis & Rheumatology Associates of South Jersey
2848 S. Delsea Drive, Ste 2C
Vineland, NJ 08360
856-794-9090

Form Effective: October 17, 2014