Center For Arthritis
And Rheumatic Diseases, P.C.

Roger W. Lidman, M.D., F.A.C.P.
Sarah B. Clarkson, M.D.
Witold A. Turkiewicz, M.D.
John V. Mansoor, M.D.
Julianne S. Orlowski, D.O.

_____
_____
_____
_____

Welcome to The Center for Arthritis and Rheumatic Diseases, P.C.

This is to confirm your appointment with Dr. at _____ on _____ In our Office.
Directions to each office are attached for your convenience. To ensure all forms are completed and ready for your physician's review, please arrive at least 30 minutes early for your appointment.

When you arrive, it is very important to bring the attached patient history form completed, any X-ray films, blood test or other results, your insurance card(s) and the referring doctor's full name and address. These items are very important for your medical record

You may be contacted by our billing department prior to your visit to verify your insurance coverage. We file your insurance for you, and a patient account representative will be assigned to you to help with your billing needs. Since your insurance company may not cover the entire cost of your visit, we do require payment at the time of service. If any of your insurance information changes, please contact our billing office as soon as possible at (757) 461-6997.

We will try to call you two days in advance of this appointment to confirm, and we must hear back from you within 24 hours of your appointment. Regardless of whether we are able to reach you to confirm your appointment, it is <u>your</u> responsibility to contact use to confirm this appointment; otherwise your appointment will be cancelled and given to another patient. A $150.00 charge will be added to your account if you fail to keep your confirmed new patient appointment.

We appreciate your cooperation and look forward to your visit. If you have any questions, please contact the office where your appointment is scheduled; the numbers are listed below.

Thank you.

816 Greenbrier Circle
Suite A
Chesapeake, VA 23310
757-461-3400 (fax) 757-461-7130

1033 Champions Way
Suite 100
Suffolk, VA 23435
757-483-2783 (fax) 757-483-6325

SYSTEMS REVIEW

Please review the following list and check any of the 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

General

Recent weight gain☐Amount:

Recent weight loss☐ Amount:

Fatigue☐

Weakness☐

Fever ☐

Eye

Pain☐

Redness☐

Loss of Vision☐

Double or Blurred Vision☐

Dryness☐

Feels like something in the eye☐

Itching Eyes☐

Ear-Nose-Throat-Mouth

Ringing in ears☐

Loss of hearing☐

Nosebleeds☐

Dryness in nose☐

Runny nose☐

Sore tongue☐

Bleeding gums☐

Sores in mouth☐

Loss of taste☐

Dryness of mouth☐

Frequent sore throats☐

Hoarseness☐

Difficulty swallowing☐

Heart

Pain in chest☐

Irregular heart beat☐

Sudden changes in heart beat☐

High blood pressure☐

Heart murmurs☐

Lungs

Shortness of breath☐

Difficulty in breathing at night☐

Swollen legs or feet☐

Cough☐

Coughing up blood☐

Wheezing (asthma)☐

Stomach

Nausea☐

Vomiting of Blood or Coffee ground material☐

Stomach pain relieved by eating☐

Jaundice☐

Increasing constipation☐

Persistent diarrhea☐

Blood in stools☐

Black stools☐

Heartburn☐

Hepatitis☐

Kidney/Urine/Bladder Difficult urination☐

Pain or burning on urination☐

Blood in urine☐

Cloudy, "smoky" urine☐

Pus in urine☐

Discharge from penis/vagina☐

Sexual difficulties☐

Prostate difficulties☐

Muscles/Joints/Bone

Morning Stiffness ☐

Lasting how long? minutes hours

Joint Pain ☐

Muscle Weakness ☐

Muscle tenderness ☐

Joint Swelling ☐

List Joints affected in the last 6 months

Skin

Easy Bruising☐

Redness☐

Hives☐

Sun Sensitive☐

Tightness☐

Nodules/Bumps☐

Hair Loss☐

Color changes of the hands or feet in the cold ☐

Neurological Systems

Headache ☐

Dizziness ☐

Fainting ☐

Muscle Spasms ☐

Loss of Consciousness ☐

Sensitivity or pain of hands and/or feet ☐

Memory loss ☐

Night sweats ☐

Excessive Worries ☐

Anxiety ☐

Easily losing temper ☐

Depression ☐

Agitation ☐

Difficulty falling asleep ☐

Difficulty staying awake ☐

Blood/Lymph Nodes

Swollen glands ☐

Tender glands ☐

Anemia ☐

Bleeding tendency ☐

Transfusion/ When?

Blood Clots ☐

For Women Only:

Age when period 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?

Patient's Name: _____ Date: _____

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No 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

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

Spouse/Significant Other: Alive/Age _____ Deceased/Age _____ Major Illnesses_____

EDUCATION (select highest level attended):

Grade School: ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 College ☐1☐ 2 ☐ 3 ☐ 4 Graduate School: ☐___

Occupation: _____ Number of hours worked per average week: _____

MEDICATIONS

Drug allergies: ☐ Yes ☐ No To What?_____

Type of reaction: _____

PRESENT 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.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Patient's Name: _____ Date: _____

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 result of taking 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)		☐	☐	☐	

Select any you have taken in the past

☐Ansaid (flurbiprofen) ☐Arthrotec(diclofenac+Misoprostil) ☐Aspirin(including coated) ☐Celebrex (celecoxib)
☐Clinoril (sulindac) ☐Daypro (oxaprozin) ☐Disalcid (salsalate) ☐Dolobid (diflunisal)
☐Feldene (piroxicam) ☐Indocin (indomethacin) ☐Lodine (etodolac) ☐Naprosyn/Aleve (naproxen)
☐Motrin/Advil (ibuprofen) ☐Mobic (meloxicam) ☐Relafen (nabumetone) ☐Oruvail (ketoprofen)
☐Tolectin (tolmetin) ☐Trilisate(choline magnesium trisalicylate) ☐Vioxx (rofecoxib) ☐Voltaren (diclofenac)

Pain Relievers	Length of Time	A Lot	Some	Not at all	Reactions
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine, Vicodin, Tylenol 3		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Tramadol (Ultram)		☐	☐	☐	
Other:		☐	☐	☐	
Corticosteroids	Length of Time	A Lot	Some	Not at all	Reactions
Prednisone/Medrol		☐	☐	☐	
Disease Modifying Antirheumatic Drugs	Length of Time	A Lot	Some	Not at all	Reactions
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Pencillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Arava		☐	☐	☐	
Other:		☐	☐	☐	
Osteoporosis Medications	Length of Time	A Lot	Some	Not at all	Reactions
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Calcitonin, injection or nasal (Miacalcin, Calimar)		☐	☐	☐	
Residronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications	Length of Time	A Lot	Some	Not at all	Reactions
Probenecid (Benemid)		☐	☐	☐	
Cochicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Others	Length of Time	A Lot	Some	Not at all	Reactions
Amitriptyline (Elavil)		☐	☐	☐	
Cyclobenzaprine (Flexeril)		☐	☐	☐	
Paroxetine (Paxil)		☐	☐	☐	
Cortisone		☐	☐	☐	
Hyalgan/Synvisc Injections		☐	☐	☐	
Glucosamine/Chondroitin Sulfate		☐	☐	☐	
Please list any herbal or nutritional supplements:					

Patient's Name: _____ Date: _____

Assignment of Benefits & Consent for Treatment

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to The Center for Arthritis and Rheumatic Diseases, P.C. for medical services rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize The Center for Arthritis and Rheumatic Diseases, P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from The Center for Arthritis and Rheumatic Diseases, P.C., and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature: _____ Date_____

Printed name of person signing: _____

Relationship to Insured (if other than patient):_____

PATIENT HISTORY FORM

Name:_____, _____, _____, _____ Birthdate:
Last Name First Name Middle Name Maiden Name Place of Birth:

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race:

Address: _____ Age:_____ Sex: ☐M ☐F
Street

_____ _____ _____ Telephone Home #
City State Zip Code Mobile #
Employer: _____ Work #

Primary Insurance: Policy #_____ Insured: _____ Subscriber:
Subscriber Employer:_____ Subscriber Social Security #:
Subscriber DOB:_____ Subscriber Home #: _____ Subscriber Work #:
Secondary Insurance: Policy #_____ Insured: _____ Subscriber:
Subscriber Employer:_____ Subscriber Social Security #:
Subscriber DOB:_____ Subscriber Home #: _____ Subscriber Work #:
Additional Insurance: Policy #_____ Insured: _____ Subscriber:
Subscriber Employer:_____ Subscriber Social Security #:
Subscriber DOB:_____ Subscriber Home #: _____ Subscriber Work #:

Next of Kin: _____ Relationship:
Emergency Contact #: _____ Name: _____ Relationship:
Who referred you to us?
The name of your physician providing your primary care:
Do you have an orthopedic surgeon? ☐ Yes ☐No If yes, Name:
Main Symptoms and Reasons for coming to see the Doctor:

Date symptoms began (approximately): _____Diagnosis:
Please list the names of other practitioners you have seen for this problem:

Patient's Name: _____ Date: _____

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: _____

PAST MEDICAL HISTORY:

Cancer☐	Heart Problems ☐	Asthma ☐	Goiter ☐
Leukemia ☐	Stroke ☐	Cataracts ☐	Diabetes ☐
Epilepsy ☐	Nervous Breakdown ☐	Stomach Ulcers ☐	Rheumatic Fever ☐
Bad Headaches ☐	Hepatitis/Jaundice ☐	Colitis ☐	Kidney Disease ☐
Pneumonia ☐	Psoriasis ☐	Anemia ☐	HIV/AIDS ☐
High Blood Pressure ☐	Emphysema ☐	Glaucoma ☐	Tuberculosis ☐

Other significant illness (please list):

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

PREVIOUS OPERATIONS:

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		

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**

Patient's Name: _____ Date: _____

Print this form