Rheumatology Associates, P.C.
8902 North Meridian St., Suite 210
Indianapolis, IN 46260
Phone: 317-844-6444
Fax: 317-848-6605

PRE APPOINTMENT QUESTIONNAIRE

Name: LAST FIRST MIDDLE INITIAL Email Address:

Address: STREET APT.# Telephone: Home ( )

CITY STATE ZIP Telephone: Cellular ( )

Social Security: Birthdate: / / Age Sex: □ F □ M

Your Employer: Emp. Address Emp. Telephone: ( )

Spouse's Employer: Emp. Address Emp. Telephone ( )

Person to call in case of emergency: Telephone: ( ) Relationship:

Due to government regulations, we are required to collect the following data on race, language and ethnicity. Please circle one of the answers for each.
Race: American Indiana/ Alaskan Native, Asian, Black or African American, Caucasian, Declined to Specify, Multi Racial/More than one Race, Native Hawaiian or other Pacific Islander, Other Race
Language: Declined to Specify, English, Other, Spanish
Ethnicity: Declined to Specify, Hispanic or Latino, Not Hispanic or Latino

Do you want a copy of the consultation sent to the referring physician? □ Yes □ No

Name of referring Physician: _____.

Address & Phone: _____.

The name of Primary Care Physician? _____.

Address & Phone: _____.

Describe briefly why you are seeing a Rheumatologist: _____.

Date symptoms began: (approximate)_____ Diagnosis given? (Please list)

PLEASE LIST THE NAME OF OTHER PRACTITIONERS YOU HAVE SEEN FOR THIS PROBLEM:

Name/Address/Phone

Name/Address/Phone

Name/Address/Phone

Name/Address/Phone

PAST PERSONAL HISTORY:

Do you have or have you had? (check is '"yes")

□ Anemia □ Ankylosing Spondylitis □ Anxiety/Depression □ Arthritis (type unknown) □ Asthma □ Bad Headaches
□ Cancer □ Cataracts □ Childhood Arthritis □ Colitis □ Diabetes □ Epilepsy
□ Gout □ Heart Problems □ High Blood Pressure □ Jaundice □ Kidney Disease □ Leukemia
□Lupus or "SLE" □ Osteoarthritis □ Osteoporosis □ Pneumonia □ Psoriasis □ Rheumatic Fever
□ Rheumatoid Arthritis □ Stomach Ulcers □ Stroke □ Kidney Disease □ Thyroid Problems
□ Other Arthritis Condition_____ □ Other significant illness: (Please list) _____.

Date of last eye examination: _____ Date of last Tuberculosis Test: _____ Date of last Bone Density: _____.

Date of last chest x-ray:_____ Date of last EKG: _____.

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

SYSTEMS REVIEW

As you review the following list, **please check any of those problems which apply to you**.

GENERAL	PSYCHIATRIC	☐ Frequent Urination
☐ Recent weight gain/Amount	☐ Depression	☐ Rash/Ulcers
☐ Recent loss of weight/Amount:	☐ Anxiety	☐ Sexual difficulties
☐ Fatigue	☐ Memory Loss	☐ Getting up at night to pass urine
☐ Fever	☐ Suicidal Thoughts	
☐ Night sweats	**PSYCHIATRIC CON'T.**	
☐ Sleep Disturbance	☐ Hallucinations	
NERVOUS SYSTEM	☐ Other	
☐ Headaches		**BLOOD**
☐ Dizziness		☐ Anemia
☐ Fainting	**HEART AND LUNGS**	☐ Bleeding tendency
☐ Muscle spasm or weakness	☐ Pain in chest	☐ Blood clots/phlebitis
☐ Numbness or tingling sensation	☐ Irregular heart beat	☐ Low platelet count
☐ Memory loss	☐ Sudden changes in heart beat	**SKIN**
☐ Seizure or tremors	☐ Shortness of breath	☐ Easy bruising
EARS	☐ Difficulty in breathing at night	☐ Redness
☐ Hearing Loss	☐ Swollen legs or feet	☐ Rash
☐ Ear Drainage	☐ High blood pressure	☐ Hives
☐ Ringing of ears/Tinnitus	☐ Heart murmurs	☐ Sun sensitive (sun allergy)
EYES	☐ Cough	☐ Tightness
☐ Pain	☐ Coughing of blood	☐ Nodules/bumps
☐ Redness	☐ Wheezing	☐ Hair loss
☐ Dry	☐ Pleurisy	☐ Color changes of hands or feet in the cold
☐ Vision Loss	**STOMACH AND INTESTINES**	☐ Tick bite last 5 years
☐ Double Vision	☐ Nausea	☐ Other
☐ Light Sensitivity	☐ Vomiting of blood or coffee ground material	**MUSCLES/JOINT/BONES**
☐	☐ Increasing Constipation	☐ Morning stiffness - Lasting how long?
NOSE	☐ Persistent diarrhea	Minutes #_____ Hours #
☐ Nosebleeds	☐ Blood in Stools	☐ Joint pain
☐ Nasal congestion	☐ Black Stools	☐ Muscle weakness
☐ Dryness	☐ Heartburn	☐ Muscle tenderness
☐ Nasal Ulcers	☐ Ulcers	☐ Joint swelling
MOUTH	☐ Acid Reflux	**List joints affected in the last 6 months**
☐ Mouth Sores	☐ Vomiting	
☐ Dry Mouth	**KIDNEY/URINE/BLADDER**	
☐ Hoarseness	☐ Pain or burning on urination	
☐ Swollen Glands	☐ Blood in Urine	
☐ Goiter	☐ Cloudy, "smokey" urine	
☐ Other	☐ Discharge from penis/vagina	

PREVIOUS OPERATIONS:

Type	Year	Type	Year
1)		4)	
2)		5)	
3)		6)	

Any previous fractures? ☐ Yes ☐ No Describe:

Any other serious injuries? ☐ Yes ☐ No Describe:

FAMILY HISTORY:

Do you know of any blood relative who has or had? (check all that apply and list relationship)

□ Rheumatoid Arthritis _____ □ Lupus or "SLE" _____ □ Osteoarthritis _____.

□ Ankylosing spondylitis_____ □ Gout _____ □ Childhood arthritis _____.

□ Osteoporosis_____ □ Arthritis (type unknown)_____.

Other Arthritis conditions:

□ Cancer_____ □ Heart Disease _____ □ Rheumatic Fever _____ □ Tuberculosis _____.

□ Leukemia _____ □ High Blood Pressure _____ □ Epilepsy _____ □ Diabetes _____.

□ Stroke _____ □ Bleeding Tendency _____ □ Asthma _____ □ Goiter _____.

□ Colitis _____ □ Alcoholism _____ □ Thyroid Problem _____ .

Serious illness of parents, children, brothers and/or sisters: _____.

_____ .

MEDICATIONS: (current)

Name of Drug	Dose (Include strength and number of pills per day)	Name of Drug	Dose (Include strength and number of pills per day)
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	
11.		11.	
12.		12.	

DRUG ALLERGIES: □ Yes □ No If yes, to what/describe

Have you ever participated in a clinical drug study? □ Yes □ No Date: _____ If yes, describe: _____.

MEDICATIONS: (PAST)

Past: 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 *effectiveness* of taking the medication and list any *reactions* you may have had.

Drug Names	Dosage	Length of Time	Please rate how effective			Reactions
			Not At All	Some	Very	
1. Cortisone/prednisone						
2. Plaquenil/Hydroxychloroquine						
3. Penicillamine						
4. Methotrexate						
5. Imuran/Azathioprine						
6. Cytoxan/Cyclophosphamide						
7. Azulfidine/Sulfasalazine						
8. Gold (shots or pills)						
9. Arava						
10. Enbrel						
11. Remicade						
12. Humira						

MARITAL STATUS: (Check one)

□ Never married □ Married □ Divorced □ Separated □ Widowed

Spouse: □ Living Age: _____ □ Deceased Age: _____ Major Illness: _____.

EDUCATION/OCCUPATION: (Circle the highest level attended)

Grade School Junior High School 6 7 8 High School 9 10 11 12 College 1 2 3 4 Graduate School

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

LIFESTYLE:

Do you smoke? □ Yes □ No

Cigarettes per day?: _____

Are you on a special diet?

□ Yes □ No

Describe_____

Caffeine Use? □ Yes □ No

Describe _____

How many alcoholic drinks do you have a week? _____

Has anyone ever told you to cut down

□ Yes □ No

Do you have concerns about sexually transmitted disease? □ Yes □ No

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

Do you wake up feeling rested? □ Yes □ No

Do you: □ Jog □ Swim □ Walk □ Cycle

Other Exercise:

Duration #_____ Minutes

Frequency #_____ Times weekly

INSURANCE:

Complete each section that applies to you. Please be exact in listing identification numbers.

PRIMARY INSURANCE

Insurance Co. Name: _____.

ID # _____ Group # _____.

If relationship to Insured is **Other** than Self, please indicate relationship and complete below: _____.

Policy Holder: Name: _____ Date of Birth: _____ .

(Insured) Employer: _____ SSN: _____ .

SECONDARY/SUPPLEMENTAL INSURANCE

Insurance Co. Name: _____.

ID # _____ Group # _____.

If relationship to Insured is **Other** than Self, please indicate relationship and complete below: _____.

Policy Holder: Name: _____ Date of Birth: _____ .

(Insured) Employer: _____ SSN: _____ .

ARE YOU SEEKING TREATMENT FOR AN INJURY? □ Yes □ No

If yes, please describe:

I authorize the release of any medical information necessary to process claims for medical services and/or to substantiate requested services by Rheumatology Associates, P.C. I hereby accept responsibility for payment of all servies rendered by Rheumatology Associates, P.C. Should any amount owed by me be placed with a thrid party for collection or litigation, I hereby agree to pay any collection fees, attorney fees, court expenses and any other relevant expenses incurred in resolving my outstanding balance.

Signature _____ Date _____.