Appointment Information

Date: ____________________
Time: ____________________
Physician: ____________________

Please arrive 30 minutes prior to your appt. time

Patient Information

Name:
First ____________________ MI ______ Last ____________________

Street Address ____________________ Apt. or Post Office Box __________

City ____________________ State __________ Zip __________

Telephone Primary: (______) ______________ __ Home __ Work __ Cell

Work: (______) ______________ Cell: (______) ______________

Date of Birth ______ / ______ / ______ Social Security # ______ - ______ - ______

Marital Status (Please Circle) Married Single Divorced Widowed

Employer: ____________________ Occupation ____________________

Email address ____________________

Who referred you to our practice? ____________________

Primary Care Physician ____________________ PCP Phone ______________

Preferred Pharmacy and Location: ____________________ Pharmacy Phone: ______________

Emergency Contact Information

Contact #1:
Name
First ____________________ MI ______ Last ____________________

Street Address ____________________ Apt. or Post Office Box __________

City ____________________ State __________ Zip __________

Telephone:
Primary: (______) ______________ __ Home __ Work __ Cell
Secondary: (______) ______________ __ Home __ Work __ Cell

Relationship to Patient (Please Circle) Spouse Parent Child Friend Other

Contact #2:
Name
First ____________________ MI ______ Last ____________________

Street Address ____________________ Apt. or Post Office Box __________

City ____________________ State __________ Zip __________

Telephone:
Primary: (______) ______________ __ Home __ Work __ Cell
Secondary: (______) ______________ __ Home __ Work __ Cell

Relationship to Patient (Please Circle) Spouse Parent Child Friend Other

Insurance Company Information

Please fill out all information below. Refer to your insurance cards. Please be advised that Premier HealthCare Associates, Inc. will file **Primary** and **Secondary** Insurance claims for you. If you have another insurance carrier, you are responsible for filing to that carrier.

Primary Insurance Company ______________________ Effective Date ___________

ID #: ______________________ Employer /Group # ______________________

Subscriber: First ________________ MI ____ Last ______________________

Subscriber Date of Birth ____/____/____ Social Security # ______-______-______

Patient Relationship to Subscriber (Please Circle) Self Spouse Child Other

Subscriber Address (if different from the patient)

Street Address ______________________ Apt. or Post Office Box __________

City ______________________ State __________ Zip __________

Secondary Insurance Company ______________________ Effective Date ___________

Subscriber ID # ________________ Employer/Group # ______________________

Subscriber: First ________________ MI ____ Last ______________________

Subscriber Date of Birth ____/____/____ Social Security # ______-______-______

Patient Relationship to Subscriber (Please Circle) Self Spouse Child Other

Subscriber Address (if different from the patient)

Street Address ______________________ Apt. or Post Office Box __________

City ______________________ State __________ Zip __________

Financial Policy

Thank you for choosing Premier HealthCare Associates as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays/High-Deductibles/Account Balances/Returned Checks
All co-payments, patient responsibility of deductibles not met, and account balances are due at time of check-in unless previous arrangements have been made prior to your appointment with a Patient Account Representative. Upon arrival for an appointment and you are unable to pay your co-payment, you will be asked to reschedule your appointment for a later date. For your convenience, we accept cash, check, VISA, MasterCard or Discover. Post-dated checks are not accepted.

A service fee of $25 will be charged to your account for all returned checks which is payable by cash or credit card. This fee is applied to your account in addition to the original check amount. You are placed on a cash or credit only basis following any returned check.

Insurance Claims
There is no doubt that health insurance benefits are confusing. Most plans do not provide 100% coverage for medical expenses. Each plan has its own set of rules, exclusions and benefit structures. **It is your responsibility to be familiar with your insurance policy's requirements.** If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving services.

Insurance is a contract between you and your insurance company. We will submit a claim to your insurance company as a courtesy to you. In order to properly file a claim with your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information at the time of each visit. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

In the event your claim is denied for a date of service, by your insurance company, due to non-payment of health insurance premiums, you will be responsible for payment in full for the services rendered. Proof of premium payment for Exchange products will be requested at time of appointments.

Participating Insurances

Aetna
AARP
Anthem Blue Cross Blue Shield (WellPoint)
Blue Cross Blue Shield Association

Cigna
Coventry Healthcare of VA
Golden Rule
Humana
Medicare (Part B)

Medicare Advantage (Part C)
Medicare Supplemental Plans (Medigap)
MultiPlan
Optima Health
Optima Family Plan (for established patient's only)
Principal Financial Group
PHCS
Tricare (Prime, Standard & Tricare for Life)
UnitedHealthcare
Virginia Health Network

We accept regular Medicaid and Optima Family Plan Medicaid for our **established** patients only.

Referrals
If you have an HMO or POS plan with which we participate, you may need a referral from your Primary Care Physician (PCP) to see a Specialist. Check your insurance card or call your insurance carrier to determine if your plan requires you to have a referral to see a Specialist. We must have the referral in the office before you are seen by the Specialist. We will ask you to reschedule your appointment in the event that your referral is not received at the time of your appointment. For this reason, it is important that you make

sure that your Primary Care Physician has sent the referral and that we have received it before you come in to the office. Another option is to bring the referral with you at the time of your appointment.

Self-pay Patients
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient is considered self-pay. Self-pay new patients are required to bring $200 at the initial appointment and are billed for the remaining balance due after the visit is complete. For all subsequent visits, payment is due in full at time of service. Established patients are eligible to receive a same day 40% cash discount for services rendered if they pay in cash. Patients paying with check or credit card are required to pay for services rendered in full; no discount will apply. Please ask to speak with a Patient Account Representative to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments
Premier HealthCare Associates requires 24-hour notice of appointment cancellation. Any appointments not canceled are subject to a "No Show" fee of $60. Any infusion center appointments not canceled are subject to a "No Show" fee of $100.

Outstanding Balance Policy
It is our office policy that all account balances be sent two statements. If payment is not made on this account, a notice of collections is sent asking you to contact our business office to pay your account in full or make payment arrangements. If no resolution can be made, the account is sent to the collection agency, or attorney, in which you are responsible for all fees incurred. You may also be subject to possible discharge from the practice.
Payment plans are available for account balances in excess of $50 in the event of a financial hardship. Payment terms are as follows: 50% of the total balance must be paid at inception of the payment plan agreement. The remaining balance is due within 6 months. A bill is sent to your mailing address each month for the amount agreed upon. If you are delinquent on a payment, your account is turned over to the collection agency where you will incur collection agency fees. All charges incurred after the inception of the payment plan are due with 30 days of receipt of the statement. Please note you may receive two separate bills from our office, one for your payment plan and one for other services rendered outside the terms of your payment plan.

Failure to comply with these payment terms may result in a dismissal from the practice.

Should the account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment and any and all applicable court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact *Pamela West*, our Business Office Manager, Monday through Friday, 8:30 am to 5:00 pm. Please call 804-288-7901, extension 398.

Authorization

Authorization to Release Information:
I authorize Premier HealthCare Associates, Inc. (PHA) to release information to my healthcare insurer, the Center for Medicare and Medicaid Services (CMS), or any other entity necessary to determine benefits and process claims related to medical services that have been provided to me. An electronic copy of this authorization will be deemed as valid as the original.
Assignment of Benefits:
I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to Premier HealthCare Associates, Inc. An electronic copy of this authorization will be deemed as valid as the original.
Financial Responsibility:
I have read the Premier HealthCare Associates Inc. Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physicians and nurses of PHA. Any fees deemed patient responsibility or are not covered by my insurance company will be due on the day of service or upon resolution of my insurance claim. PHA reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied. It is my responsibility to notify PHA of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original.

Patient Signature: ______________________________ Date: ______________

Please print your name: ______________________________

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, ______________________________ have received a copy of the Premier HealthCare Associates' Notice of Privacy Practices dated September 23, 2013.

I understand that I may ask questions to the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

____
Patient Signature

____
Date

____
Authorized Representative of Patient

____
Relationship to Patient

____
Date

Authorization to Disclose Patient Information

Patient Name: ____

Date of Birth: _______________ SSN: ______________________

Your Premier HealthCare Associates Physican(s) **(Please circle) Dr. Bailey, Dr. Crognale, Dr. Moroianu, Dr. Mueller, Dr. Spring, Dr. Strachan**

I authorize the Physicians and staff of **Premier HealthCare Associates** to discuss (as indicated) with the below listed individuals.

Please enter full name and date of birth and relationship to the patient for each individual.

Full Name	**Date of Birth**	**Relationship to Patient**	**Contact Telephone Number**	**Healthcare, treatment, Billing Issues Please circle all that apply.**
				Healthcare Treatment Billing
				Healthcare Treatment Billing
				Healthcare Treatment Billing
				Healthcare Treatment Billing

I request that Premier HealthCare Associates, Inc. <u>not</u> discuss my healthcare treatment and/or billing issues with:

____

*** Please note - This authorization is optional and <u>does not</u> grant access to the patient's medical records. All requests for medical records must be authorized by the patient in writing. This allows our staff to speak to these individuals regarding your current healthcare, treatment or billing issues.

Please note that this authorization revokes previous authorizations.

I understand this authorization may be revoked by me at any time and must be done so in writing.

Signature of Patient: ____________________________ Date:__________

Patient Representative: _________________________ Date:_________ Relationship: _______________

Updated: 01/16/2017

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Co-pays/High-Deductibles/Account Balances/Returned Checks

All co-payments, patient responsibility of deductibles not met, and account balances are due at time of check-in unless previous arrangements have been made prior to your appointment with a Patient Account Representative. Upon arrival for an appointment and you are unable to pay your co-payment, you will be asked to reschedule your appointment for a later date. For your convenience, we accept cash, check, VISA, MasterCard or Discover. Post-dated checks are not accepted.

I understand that if I have a high deductible insurance plan and if the deductible is not met, I will be required to pay a $150.00 deposit at the time of service. Once my insurance has been billed and the claim adjudicated, any balance will be my responsibility.

A service fee of $25 will be charged to your account for all returned checks which is payable by cash or credit card. This fee is applied to your account in addition to the original check amount. You are placed on a cash or credit only basis following any returned check.

Insurance Claims

There is no doubt that health insurance benefits are confusing. Most plans do not provide 100% coverage for medical expenses. Each plan has its own set of rules, exclusions and benefit structures. **It is your responsibility to be familiar with your insurance policy's requirements.** If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving services.

Insurance is a contract between you and your insurance company. We will submit a claim to your insurance company as a courtesy to you. In order to properly file a claim with your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information at the time of each visit. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

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Participating Insurances

- Aetna
- AARP
- Anthem Blue Cross Blue Shield (WellPoint)
- Blue Cross Blue Shield Association
- Cigna
- Coventry Healthcare of VA
- Golden Rule
- Humana
- Medicare (Part B)
- Medicare Advantage (Part C)
- Medicare Supplemental Plans (Medigap)
- MultiPlan
- Optima Health
- Optima Family Plan (for established patient's only)
- Principal Financial Group
- PHCS
- Tricare (Prime, Standard & Tricare for Life)
- United Healthcare
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Over →

appointment in the event that your referral is not received at the time of your appointment. For this reason, it is important that you make sure that your Primary Care Physician has sent the referral and that we have received it before you come in to the office. Another option is to bring the referral with you at the time of your appointment.

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Assignment of Benefits:

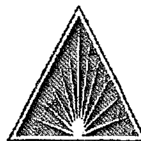
I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to Premier HealthCare Associates, Inc. An electronic copy of this authorization will be deemed as valid as the original.

Financial Responsibility:

I have read the Premier HealthCare Associates Inc. Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physicians and nurses of PHA. Any fees deemed patient responsibility or are not covered by my insurance company will be due on the day of service or upon resolution of my insurance claim. PHA reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied. It is my responsibility to notify PHA of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original.

Patient Signature: ______________________________ Date: ______________

Please print your name: ______________________________



AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

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.**

Example:

Example

LEFT RIGHT LEFT

LEFT RIGHT

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:					

Patient's Name ____________ Date ____________ Physician Initials ______

Patient History Form © 1999 American College of Rheumatology

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 ________

Patient History Form © 1999 American College of Rheumatology

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 _______

Patient History Form © 1999 American College of Rheumatology

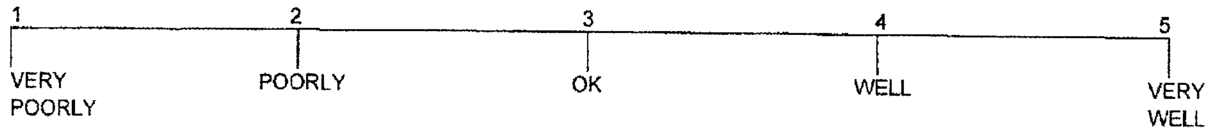
ACTIVITIES OF DAILY LIVING

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 ☐

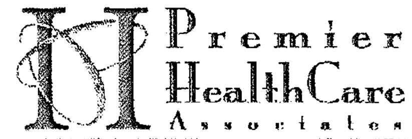
Do you have a medically related lawsuit pending? .... Yes ☐ No ☐

Patient's Name ____________ Date ____________ Physician Initials ________

Patient History Form © 1999 American College of Rheumatology

Full Name: ____________________
Date of Birth: ____________________

PERSONAL MEDICATION REGISTRY



PLEASE LIST ANY ALLERGIES: ____________________

Please include all prescription and over the counter medication. PLEASE PRINT

MEDICATION NAME	DOSE (mg, units, mcg, etc.)	INSTRUCTIONS	FOR TREATMENT OF	PRESCRIBING Dr.
Example: DIOVAN	160mg	1 tablet by mouth once a day	high blood pressure	Dr. John Doe
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

APPOINTMENT DATE ____________________

PHYSICIAN NAME ____________________