Patient Registration
Colorado Arthritis Center P.C

*PATIENT NAME(First,MI, Last)*_____ *SEX : Male Female*

*HOME PHONE:*_____ *CELL:*_____ *MARTIAL STATUS M S D W*

*ADDRESS:*_____ *City*_____ *ST:*_____ *ZIP:*_____

*BIRTH DATE:*_____ *AGE:*_____

*SOCIAL SECURITY #:*_____ *EMPLOYER:*_____ *OCCUPATION:*_____

*Emergency Contact Name:*_____ *Emergency Contact Phone:*_____

RESPONSIBLE PARTY

*NAME:*_____ *HOME PHONE#:*_____

*ADDRESS:*_____ *WORK PHONE#:*_____

*SOCIAL SECURITY #:*_____ *EMPLOYER:*_____

*RELATIONSHIP : Spouse Sibling Parent Daughter Son Partner Other:*_____

REFERRING PHYSICIAN

*NAME:*_____

*ADDRESS:*_____

*PHONE#:*_____

PRIMARY PHYSICIAN

*NAME:*_____

*ADDRESS:*_____

*PHONE#:*_____

INSURANCE INFORMATION

*PRIMARY INS:*_____

*INSURED NAME:*_____

*INSURED BIRTH DATE:*_____

*MEMBER ID#*_____

*GROUP #:*_____

RELATIONSHIP : SELF SPOUSE OTHER

*SECONDARY INS:*_____

*INSURED NAME:*_____

*INSURED BIRTH DATE:*_____

*MEMBER ID#*_____

*GROUP#:*_____

RELATIONSHIP: SELF SPOUSE OTHER

I hereby authorize Colorado Arthritis Center.P.C to release any medical information to my insurance carrier, should my injury be work related ,I authorize release of any medical information related to that injury to my employer or representative. I authorize my medical records to be release to any physician Colorado Arthritis Center refers me to. I authorize payment of medical benefits directly to Colorado Arthritis Center, PC for all services rendered and agree to pay any unpaid balance left by my insurance company.

*SIGNATURE:*_____ *DATE:*_____

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ☐ F ☐ M

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

Whom do we thank for referring you here? _____

Name of your primary care physician: _____

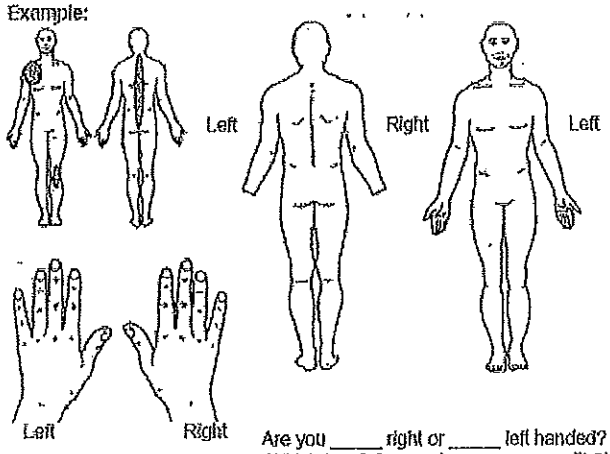
Describe briefly your present symptoms: _____

When did your symptoms start? _____

What diagnosis have you been given, if any?

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

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

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

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

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	
Osteoarthritis	❑	❑	→	
Rheumatoid arthritis	❑	❑	→	
Gout	❑	❑	→	
Lupus or "SLE"	❑	❑	→	
Ankylosing spondylitis	❑	❑	→	
Childhood arthritis	❑	❑	→	
Sjogren's syndrome	❑	❑	→	
Osteoporosis	❑	❑	→	
Psoriasis/psoriatic arthritis	❑	❑	→	

PAST MEDICAL HISTORY

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

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type)	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Other significant illnesses (please list):

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

Do you smoke? ❑ Yes – How much? _____ ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

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

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

Do you wake up feeling rested? ❑ Yes ❑ No

Non-steroidal Anti-Inflammatory Drugs(NSAIDs)

Circle any/all medications that apply

Arthrotec (diclofenac/misoprostol)	ibuprofen (Motrin, Advil, Duexis)	piroxicam (Feldene)
Aspirin	indomethacin (Indocin, Tivorbex)	rofecoxib (Vioxx)
celecoxib (Celebrex)	ketoprofen (Oruvail)	salsalate (Disalcid)
diclofenac (Voltaren, Zipsor)	meloxicam (Mobic)	sulindac (Clinoril)
diflunisal (Dolobid)	nabumetone (Relafen)	
etodolac (Lodine)	naproxen (Naprosyn, Vimovo)	

Pain Relievers — Please check if they helped	A Lot	Some	Not At All
Acetaminophen (Tylenol)	☐	☐	☐
Codeine (Tylenol 3)	☐	☐	☐
Oxycodone (OxyContin)	☐	☐	☐
Hydrocodone (Vicodin, Norco, Lortab)	☐	☐	☐
Oxymorphone (Opana)	☐	☐	☐
Other:	☐	☐	☐
Disease Modifying Antirheumatic Drugs (DMARDS)			
Hydroxychloroquine (Plaquenil)	☐	☐	☐
Methotrexate (Rheumatrex)	☐	☐	☐
Azathioprine (Imuran)	☐	☐	☐
Sulfasalizine (Azulfidine)	☐	☐	☐
Anti-TNFs (Enbrel, Remicade, Humira, Cimzia, Simponi)	☐	☐	☐
Please circle which anti-TNF			
Acemtra (tocilizumab)	☐	☐	☐
Orencia (abatacept)	☐	☐	☐
Rituxan (rituximab)	☐	☐	☐
Xeljanz (tofacitinib)	☐	☐	☐
Stelara (ustekinumab)	☐	☐	☐
Otezla (apremilast)	☐	☐	☐
Cosentyx (secukinumab)	☐	☐	☐
Cyclophosphamide (Cytoxan)	☐	☐	☐
belimumab (Benlysta)	☐	☐	☐
Other:	☐	☐	☐
Osteoporosis Medications			
Estrogen (Premarin)	☐	☐	☐
Alendronate (Fosamax)	☐	☐	☐
Risedronate (Actonel)	☐	☐	☐
Ibandronate (Boniva)	☐	☐	☐
Prolia (denosumab)	☐	☐	☐
Calcitonin injection or nasal (Miacalcin,Calcimar)	☐	☐	☐
Forteo (teriparatide)	☐	☐	☐
Other:	☐	☐	☐
Gout Medications			
Probenecid (Benemid)	☐	☐	☐
Colchicine (Colcrys)	☐	☐	☐
Allopurinol (Zyloprim/Lopurin)	☐	☐	☐
Pegloticase (Krystexxa)	☐	☐	☐
Lesinurad (Zurampic)	☐	☐	☐
Other:	☐	☐	☐
Other Medications			
Gabapentin (Neurontin) or pregabalin (Lyrica)	☐	☐	☐
Cortisone/Prednisone	☐	☐	☐
Hyalgan/Synvisc/Euflexxa Injection	☐	☐	☐
Other:	☐	☐	☐

Please list supplements: _____

If you have participated in any clinical trials? Yes No Please list _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?

Please list any medications that you are currently taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, turmeric, laxatives, calcium, etc.

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

What medications have you taken previously?

PERSONAL HISTORY

What is your highest educational level?

☐ High school ☐ Some college courses ☐ College graduate
☐ Advanced degree

What is your current or past occupation?

Are you currently working? : ☐ Yes ☐ No

If yes, hours/week _____
If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No

If yes, for what disability? _____
What date did this disability begin?

With whom do you currently live?

How much exercise do you get each week?

What kind of exercise?

FAMILY HISTORY

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

Number of siblings: _____ Number living _____

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

Health of children:

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ☐ Never done ☐ Negative ☐ Positive Date test performed: _____

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Morning stiffness
  - Lasting how long ____ Minutes
  - ____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye

MOUTH
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Recent increase in tooth cavities

NOSE
- ☐ Nosebleeds
- ☐ Loss of smell

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw while chewing

NECK
- ☐ Swollen glands
- ☐ Tender glands

HEART AND LUNGS
- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain relieved by food
- ☐ Vomiting of blood/"coffee grounds"
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

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

BLOOD
- ☐ Anemia
- ☐ Bleeding tendency

SKIN
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive
- ☐ Skin tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling in hands/feet
- ☐ Memory loss
- ☐ Muscle weakness

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

For women only:

Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
☐ No ☐ Yes If yes, at what age: _____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ☐ Yes ☐ No
How many days apart? _____

Name (First, Last):_____DOB:_____Date_____Physician_____

Please mark the response which best describes your usual abilities over the past few days, weeks or months.

OVER THE LAST WEEK, Were you able to	Without Difficulty	Some Difficulty	Very Difficult	UNABLE To Do
1.Dress yourself, including tying shoelaces and doing buttons?	___0	___1	___2	___3
2. Get in and out of bed?	___0	___1	___2	___3
3. Lift a full cup or glass to mouth?	___0	___1	___2	___3
4. Walk outdoors on flat ground?	___0	___1	___2	___3
5. Wash and dry your entire body?	___0	___1	___2	___3
6. Get in and out of the car?	___0	___1	___2	___3
7. Bend down and pick up clothing from the floor?	___0	___1	___2	___3
8. Turn regular faucets on and off?	___0	___1	___2	___3
9. Can you stand up from armless chair?	___0	___1	___2	___3
10. Climb five steps?	___0	___1	___2	___3
11. Open jars which have been previously opened?	___0	___1	___2	___3
12. Do chores (house work or vacuuming)?	___0	___1	___2	___3

ASSESSMENT OF PAIN AND DISEASE ACTIVITY

PAIN: How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate how severe your pain level has been.

NO PAIN SOME PAIN PAIN AS BAD AS IT COULD BE

O O O O O O O O O O O O O O O O O O O O O O

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

DISEASE ACTIVITY:Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing(10 being the worst).

GREAT FAIR POOR

O O O O O O O O O O O O O O O O O O O O O O

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