The Center for
RHEUMATOLOGY LLP

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint/Reason for visit: _____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: ex: Folic Acid	**Dosage:** ex: 1mg	**Instructions:** ex: 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction:** ex: Nausea

Past Medical History: Please check if you or **your immediate family** have a history of any condition below:

	self	family member		self	family member
Alcoholism	☐	☐ _____	Kidney Disease	☐	☐ _____
Anemia	☐	☐ _____	Liver Disease	☐	☐ _____
Autoimmuue Disorder	☐	☐ _____	Lupus	☐	☐ _____
Cancer	☐	☐ _____	Lung Problems	☐	☐ _____
Congestive Heart Failure	☐	☐ _____	Osteoarthritis	☐	☐ _____
Colitis	☐	☐ _____	Osteoporosis	☐	☐ _____
COPD	☐	☐ _____	Psoriasis	☐	☐ _____
Crohn's Disease	☐	☐ _____	Prostate	☐	☐ _____
Depression	☐	☐ _____	Rheumatoid Arthritis	☐	☐ _____
Diabetes	☐	☐ _____	Scleroderma	☐	☐ _____
GERD	☐	☐ _____	Seizures	☐	☐ _____
Gout	☐	☐ _____	Sexually Transmitted Disease	☐	☐ _____
Glaucoma	☐	☐ _____	Stomach Ulcers	☐	☐ _____
Heart Disease	☐	☐ _____	Stroke	☐	☐ _____
High Cholesterol	☐	☐ _____	Thyroid Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____	Tuberculosis	☐	☐ _____
Hepatitis	☐	☐ _____	Pulmonary Hypertension	☐	☐ _____

Other Major Illnesses: _____

_____

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Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584–4953 | Fax: (518) 584–7916

Surgical History: Please list all past operations with dates.

_____

_____

_____

_____

Social History:

Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) ☐ Male ☐ Female

Marital Status: (select one) ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:_____

Race: (select one)
☐ Caucasian ☐ African American ☐ Asian ☐ Native American
☐ Native Alaskan ☐ Native Hawaiian ☐ Pacific Islander ☐ Declined

Ethnicity: (select one) ☐ Hispanic ☐ Non–Hispanic ☐ Declined

Primary Language: (select one) ☐ English ☐ French ☐ Spanish ☐ Other:_____

Occupation:_____ Number of Children:_____
Number of Pregnancies:_____ Number of Miscarriages:_____

Tobacco Use:
☐ Never smoked
☐ Currently smoke every day: Number of packs per day: _____
☐ Currently smoke some days
☐ I have quit smoking: Age when stopped: _____

Alcohol Use:
How many days per week do you drink? _____ How drinks per day? _____
Have you ever had a problem with alcohol? ☐ Yes ☐ No

Illicit / Recreational Drug Use:
Do you use drugs? ☐ Yes ☐ No How often? _____
Have you ever had a problem with illicit drug use? ☐ Yes ☐ No

Exercise:
☐ Yes: How often? _____ ☐ No

Contacts:

Pharmacy:
Retail:_____ Address/Phone:_____
Retail:_____ Address/Phone:_____
Mail order:_____ Address:_____

Names of Physicians/Other Specialists which are treating you:
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____

SYSTEMS REVIEW

Name:_____ DOB:_____

Reason for your visit today:

_____

In the past <u>month</u> have you experience any of the following? Check box if Yes.

- ☐ Chills
- ☐ Fatigue
- ☐ Fevers
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Cavities
- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Trouble swallowing/dysphagia
- ☐ Nosebleed/epistaxis
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Jaw pain
- ☐ Nasal sores
- ☐ Oral ulcers
- ☐ Red eye
- ☐ Sinusitis/sinus congestion
- ☐ Tinnitus/ringing in ears
- ☐ Cough
- ☐ Hemoptysis/coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Edema/leg swelling
- ☐ Palpitations
- ☐ Raynaud's/purple fingers in cold
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Blood in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Dysuria/painful urination
- ☐ Genital lesions
- ☐ Hematuria/blood in urine
- ☐ Recurrent UTI
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Polydipsia/increased thirst
- ☐ Extremity numbness
- ☐ Gait disturbance/diffulty walking
- ☐ Headache
- ☐ Memory loss
- ☐ Tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Frequent infections
- ☐ Hives
- ☐ Itching
- ☐ Nail changes
- ☐ Photosensitivity/sun sensitive
- ☐ Psoriasis
- ☐ Rash
- ☐ Scalp tenderness
- ☐ Skin lesion
- ☐ Back pain
- ☐ Height loss
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness:
  How long?_____
- ☐ Muscle cramping
- ☐ Myalgia/muscle pain
- ☐ Neck pain
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy/
  swollen lymph nodes

<u>IF you have rheumatoid arthritis:</u>

From a scale of 1 (normal) to 10 (maximum), how much does the rheumatoid affect your activities of daily living? (E.g., cleaning, washing, cooking, shopping, etc.)

Your answer:_____

Have you recently experienced or developed any of the following?

Infection? If so, which type and did you receive antibiotics? _____

Allergy? To what and what was the reaction? _____

Were diagnosed with a new medical condition? _____

Did you have any surgery? Who was your surgeon? _____

Were you prescribed any new medications? _____

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The Center for
RHEUMATOLOGY LLP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name:_____ D.O.B._____

By signing this authorization, I authorize The Center for Rheumatology, LLP to use and/or disclose certain protected health information (PHI) about me to:

1. Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information. →

Person or Entity to Receive the Information:

_____

_____

_____

1a. Name and phone number of your emergency contact:_____

2. Do you give our office permission to leave you a detailed message? ☐ Yes ☐ No

If we must leave a detailed message, please check the preferred method(s) of contact:

☐ Home phone ☐ Cell phone ☐ Work phone

3. Please initial:

_____ I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV–RELATED INFORMATION unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

I understand that The Center for Rheumatology, LLP will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from The Center for Rheumatology, LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Printed Name of Patient or Legal Guardian:_____

Signature of Patient or Legal Guardian:_____

Relationship to Patient:_____ Date:_____

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