

NAME: \_\_\_\_\_ APPT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

REFERRING MD: \_\_\_\_\_

( ) MAILED HISTORY FORM: \_\_\_\_\_

( ) RECEIVED HISTORY FORM \_\_\_\_\_

( ) RECEIVED MD REFERRAL \_\_\_\_\_

( ) DPX ALSO

( ) PATIENT TOLD TO COME 1/2 HOUR EARLY TO COMPLETE FORMS

NOTE \*\*\*We Are a "FRAGRANCE FREE OFFICE"\*\*\*



**\*\*\*We are a "FRAGRANCE FREE OFFICE"\*\*\***

Please see our Office Policy for Details.

**Robin K Dore MD Inc**  
12791 Newport Ave., Suite 201, Tustin CA 92780  
(714) 505-5500 FAX (714) 505-3381

Dear \_\_\_\_\_ Appointment Date: \_\_\_\_\_, 2022 \_\_\_\_ am \_\_\_\_ pm

You are scheduled for an appointment. **These are our policies:**

**See our "Fragrance Free" Office Policy Referral required.**

You must have a **referral** from your **treating physician** stating the reason for the referral. This can be a faxed prescription referring you to this office.

This office only provides **adult** (usually 30 and older) **rheumatology care** for arthritis and related auto-immune diseases; osteoporosis care may also be provided. Patients are not seen for "second opinions."

You must have a **primary physician** for your general medical (and emergency) care as well as routine physical exams. For example, your primary physician is responsible for your routine screening for various diseases, such as for breast, cervical, colon and prostate cancer. Breast, genitourinary and rectal examinations are not performed by Dr. Dore as part of her rheumatology care.

**Forms to complete.**

Fully complete, sign and return a **week** prior to your appointment the enclosed: patient history, financial responsibility statement and insurance billing authorization. We reserve the right to cancel appointments if the forms have not been received.

**Bring medical records.**

Bring any lab results, x-ray reports or other information relating to your disease. Ask your doctor in writing to send records here.

**Payment.**

Payment in full is required at the time services are rendered for any **"Out of Network"** Patient. You will receive a receipt showing the treatment, charge and diagnosis. You can use this to seek insurance reimbursement. **Medicare and Blue Shield of California** PPO(Commercial Plans) patients are responsible for deductibles and co-payments deemed by your insurance company as Patient Responsibility – these are paid at visits.

**Credit Cards Accepted:** Visa, AMEX and MasterCard **ONLY**.

**Insurance billing.**

**Except for Medicare and Blue Shield of California PPO (Commercial Plans Only).** Dr Dore is **NOT** a **Preferred Provider for any Blue Shield PPO "Individual/Family Plans" -IFPs)**, we do not bill insurance except as a courtesy – and only to those insurers we already submit to electronically.

Patients are responsible for amounts not paid by their insurer for medical services. **Medicare** patients please note: We may bill your secondary insurance(s). You may have to pay any amount not paid by your secondary insurance(s).

**Communication:** Our office may communicate with our patients by telephone and/or electronic methods, such as our: **Patient Portal**.

**Please Bring Your Insurance Card(s) to your appointment. If you are faxing/mailing your completed New Patient Packet, please include your insurance card(s) with your forms.**

**No IPAs/HMO/"Senior" Plans/ PPOs/Covered CA/Exchange.**

This office is **NOT** a member of **any** independent physician organization (IPA), HMO, "senior plan" or preferred provider organization (PPO) or ANY Covered CA/Exchange Plans. **Exception: Blue Shield of CA PPO (Commercial Plans-ONLY).** Dr Dore is considered **"Out of Network"** for all **Blue Shield of CA "Individual/Family Plans"**, eg, **Platinum, Gold, Silver Plans, etc...** It is the patient's responsibility to call and confirm with their own insurance plan to confirm.

**No Primary Medi-Cal, Medicare/Medi-Cal, or Cal Optima**

This office does **not** see Patients with these coverages. We reserve the right to stop seeing Medicare patients if their Medicare becomes secondary.

**No Workers' Compensation or accident / lawsuits.**

This office also does not see new patients with injuries, job related or otherwise, or problems which may involve a pending or potential lawsuit.

Any new patient with an injury, accident or problem involving an existing or potential lawsuit or workers compensation claim will not be seen and any visit will be terminated upon disclosure of such matters.

**\*\*\*Please: Do not wear anything scented (perfume, cologne, body powder, after shave lotion, etc.) to the office.** Dr. Dore is **highly allergic** to these items. If you wear any such items your appointment may be canceled. You would have to reschedule. **See our "Fragrance Free" Office Policy.**

**Cancellations.** If you cannot keep this or any other appointment, please advise us as early as possible. We reserve the right not to reschedule patients who cancel.

Call the office if you have any questions about our policies. 714-505-5500. email: [research@robinkdorem.com](mailto:research@robinkdorem.com)

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*Dr. Dore is a board certified rheumatologist. She is a Clinical Professor of Medicine at UCLA, and lectures house staff at Harbor-UCLA Medical Center. In addition to her practice, Dr. Dore is a paid speaker, consultant and/or researcher for pharmaceutical companies regarding medications prescribed by physicians, including her. She is also a paid consultant to other companies, including prescription benefit plans.* Document1

Full payment is required from you at the time of the office visit for all Primary insured **“Out of Network”** Patients. Blue Shield of CA Plans, Medicare and Medi-Cal patients must pay any applicable deductible, co-payment or share of cost.) We are **NOT** a member of any preferred provider organization (except Dr. Dore is a California Blue Shield PPO preferred provider for **Commercial Plans only**) or independent physician association (IPA) or HMO. We will file primary Medicare claims. We will bill third party coverage as a courtesy if already do so electronically. However, you are responsible for any amount not paid except where applicable federal or state laws limit patient’s responsibility.

<b>Name</b>		<b>Cell / Mobile No:</b>	
<b>Address</b>		<b>Home No:</b>	
<b>City</b>		<b>Last 4 of SSN</b>	<b>Sex:</b>
<b>State/Zip</b>		<b>Birth Date</b>	
<b>Marital</b>	( ) Single ( ) Married ( ) Divorced ( ) Widowed/Widower		
<b>Patient Employer</b>	<b>Patient e-mail address:</b>		
<b>Spouse</b>	<b>Primary Pharmacy Name/Phone:</b>		
<b>Spouse Employer</b>		<b>Spouse Work Tel</b>	
<b>Friend/relative (other than spouse) to call in emergency:</b>			
<b>Friend/relative Tel</b>		<b>Relationship</b>	
<b>Primary Insurance</b>		<b>Secondary Ins</b>	
<b>Policy No</b>		<b>Policy No</b>	
<b>Group No</b>		<b>Group No</b>	
<b>Policyholder</b>		<b>Policyholder</b>	
<b>Primary MD</b>		<b>Tel</b>	
<b>Orthopedist</b>		<b>Tel</b>	
<b>Gynecologist</b>		<b>Tel</b>	
<b>Other</b>		<b>Tel</b>	

Adult (usually 30 or older) rheumatology consultation and treatment are provided solely for arthritis and related auto-immune diseases; osteoporosis care is provided for some patients. Therefore, it is required that all patients have a primary care physician (internist, family or general practitioner) and appropriate specialists for their other medical problems and for emergencies.

You must see your primary physician for routine physical examinations, including appropriate screening for various diseases, including screening for breast, cervical, colon and prostate cancer, all of which can be fatal if undetected. Breast, genitourinary and rectal examinations are not performed by our physicians as part of providing rheumatology care.

We encourage you to discuss fees prior to your appointment to avoid any misunderstandings.

Our fees are for Rheumatology consultation and care and for any x-ray or lab services done in our office. Any additional studies (lab, xray, EMG, MRI, CT scan, etc.) not done in our office will be billed directly to the patient by the appropriate outside lab, physician or x-ray facility that does those tests.

AGREED TO:

Patient Sign:

\_\_\_\_\_

Date: \_\_\_\_\_

Robin K. Dore, MD, Inc.

## INSURANCE AUTHORIZATION AGREEMENT

The patient hereby provides **Robin K. Dore, MD, Inc.** with the following authorizations relating to insurance, Medicare and/or other coverage available to the patient; such authorizations shall apply to past, present and future services furnished by **Robin K. Dore, MD, Inc.**

### Authorization of Payment of Benefits

I authorize payment directly to: **Robin K. Dore, MD, Inc.**, for services furnished to me. I will pay all charges not fully paid by insurance, Medicare and/or other coverage. I authorize release of my insurance information to a lab or other outside facility so they can bill my insurance directly for their services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Authorization to Release Information

I authorize, **Robin K. Dore, MD, Inc.** (and all physicians employed thereby) to release any information acquired in the course of my examination and treatment to my insurer, Medicare and/or provider of other coverage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### (1) Medicare Authorization and (2) Medicare Authorization for Prolonged Treatment (YE 12/31/2022) and (3) Addendum

#### Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Robin K. Dore, MD, Inc.** for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

#### Medicare Authorization for Prolonged Treatment (YE 12/31/2022)

I request that payment under the medical insurance program be made either to me or to **Robin K. Dore, MD, Inc.** on any bills for services furnished me by **Robin K. Dore, MD, Inc.** and/or **Robin K. Dore, MD**, during the period **OCTOBER 1, 2021 TO DECEMBER 31, 2022.**

#### Medicare HMO Addendum

I know that Robin K. Dore, MD is **NOT** a member of any Medicare HMO and if I belong to or sign up for a Medicare HMO, I must pay Robin K. Dore, MD for her services. It is my choice to see Dr Dore (and pay) or go to a rheumatologist on my HMO plan.

MEDICARE No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Group: Robin K. Dore , M.D., Inc.

**HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS SEEKING TREATMENT FOR ARTHRITIS AND RELATED DISEASES**

Appointment Date:	Time:	Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:	Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic
Name:	Age:	Date of Birth:	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referred by: <input type="checkbox"/> Self <input type="checkbox"/>	who is <input type="checkbox"/> MD <input type="checkbox"/> Friend <input type="checkbox"/> Health professional <input type="checkbox"/> Other		
Your primary physician:	The names of your other types of doctors listed below		
Orthopedic Surgeon <input type="checkbox"/> None <input type="checkbox"/>	Gynecologist <input type="checkbox"/> None <input type="checkbox"/>		
Date of Last →	Physical Exam:	Chest X-ray:	Pap Smear:
Dental Exam:	Lab Tests:	Eye Exam:	Mammogram:

- Yes  No Is your problem work related?
- Yes  No Do you have any injury, accident or problem - with an existing or potential lawsuit?
- Yes  No Are you receiving or applying for disability?
- Yes  No Are you receiving or applying for workers compensation?

**HISTORY OF PRESENT PROBLEMS: What Brings you to a Rheumatologist?**

**Began:** \_\_\_\_\_ **Describe your symptoms**

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<b>Joints:</b> <input type="checkbox"/> Swelling	<input type="checkbox"/> Pain when move	<b>Muscles:</b> <input type="checkbox"/> Pain when used	<input type="checkbox"/> Weakness	<input type="checkbox"/> Tender to touch
<input type="checkbox"/> Tender to touch	<input type="checkbox"/> Reduced movement	<b>Morning stiffness</b> - for how long: _____		

Joints affected in the last 6 months: \_\_\_\_\_

Muscles affected in the last 6 months: \_\_\_\_\_

Who have you seen for this problem?  No one

Have you seen a rheumatologist ?  No Who? \_\_\_\_\_ When? \_\_\_\_\_

Were you given a diagnosis?  No What? \_\_\_\_\_ When? \_\_\_\_\_

WHAT TREATMENT DID YOU HAVE?	Was it Effective?	Was it Effective?
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medication (List pages 3 and 4)
<input type="checkbox"/> Appliance (cane, walker)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical therapy
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Psychological counseling
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Surgery (List next page)
<input type="checkbox"/> Joint injected or Aspirated	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trigger point injection
<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other:

**WHAT IS YOUR MEDICAL HISTORY?** **Do you have, or have you had, any of the following problems?** (Check which ones) List any other problems not mentioned.

<input type="checkbox"/> AIDs or Aids related complex	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney disease/stones	<input type="checkbox"/> Thyroid disease <input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hyperparathyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental health problems	<input type="checkbox"/> Inflammatory bowel disease
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Inflammatory Eye disease (Iritis, uveitis, episcleritis)
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Positive TB Skin test
<input type="checkbox"/> Cancer :	<input type="checkbox"/> Heart disease/heart attacks	<input type="checkbox"/> Pleurisy/fluid on lungs	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Congestive heart failure:	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers Bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Strokes <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Venereal disease
<b>Please list any other medical problems not mentioned:</b>			<input type="checkbox"/> Rheumatic fever

**WHAT IS YOUR SURGICAL HISTORY?**

**Have you had any of kind of surgery, in or out of a hospital?**  **Yes**  **No** If yes, describe the surgeries below.  
Surgery includes plastic/cosmetic surgery or procedures (breast implants, collagen injections, lifts, tucks, etc.)

What operation was performed:	When:	Who performed the operation:	Where?

**Have you ever had any**

Broken bones or fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Which bone?
Other major injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Describe
Transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Where?

**WHAT IS YOUR FAMILY MEDICAL HISTORY?**

Father	<input type="checkbox"/> Alive/age	Current health	<input type="checkbox"/> Dead/ age died	Cause of death
Mother	<input type="checkbox"/> Alive/age	Current health	<input type="checkbox"/> Dead/ age died	Cause of death
Number of Brothers	Number alive	Number dead	Age died	Cause of death
Number of Sisters	Number alive	Number dead	Age died	Cause of death
Number of Children	Number alive	Number dead	Age died	Cause of death
Ages of Living Children				
Major illnesses of Children				

**Has any blood relative (parent, grandparent, aunt, uncle, sibling, child, etc.) had any of the following conditions?**

Check if yes	Relation	Check if yes	Relation
<input type="checkbox"/> Ankylosing spondylitis	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Arthritis (type unknown)	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Childhood arthritis	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Congestive heart failure	_____
<input type="checkbox"/> Fibromyalgia	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Lupus or SLE	_____	<input type="checkbox"/> Heart problems	_____
<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Osteoporosis	_____	<input type="checkbox"/> Kidney disease/stones	_____
<input type="checkbox"/> Psoriasis	_____	<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Rheumatoid arthritis	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Other arthritis condition	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Tuberculosis (TB)	_____
<input type="checkbox"/> Bleeding tendency	_____	<input type="checkbox"/> Ulcer	_____
		<input type="checkbox"/> Inflammatory Eye disease	_____

**Please list any other family medical problems not mentioned.**

**SOCIAL HISTORY**

Occupation/ Major Activities     \_\_\_\_\_ Employment situation:     Full-time     Part-time     Unemployed     Retired     Disabled  
 Homemaker     Student    Time spent weekly working, doing housework and/or going to school \_\_\_\_\_

Education    Years of school attended: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status    Check all that apply     Never married     Married     Cohabiting     Separated     Divorced     Widowed  
Spouse/significant other:     Alive/age     Dead/age died    Current health/cause of death \_\_\_\_\_

Home Situation    Live in:  House     Apartment     Condo     Yes     No    Stairs to climb, If yes, how many \_\_\_\_\_    Primary Language: \_\_\_\_\_  
Live:     Alone     With parents (#) \_\_\_\_\_     Spouse     Children (#) \_\_\_\_\_     Siblings (#) \_\_\_\_\_     Others (#) \_\_\_\_\_  
Do you do most of the:    Housework?     Yes     No    Shopping?     Yes     No    Yardwork?     Yes     No

Exercise/Hobbies    Do you     Jog     Swim     Walk - how long, how briskly? \_\_\_\_\_    Hobbies? \_\_\_\_\_

Travel     Yes     No    Have you travelled in the last few years?    If so, where: \_\_\_\_\_  
Hike/Camp     Yes     No    Have you hiked/camped in the last few years?    If so, where: \_\_\_\_\_  
 Yes     No    Have you had any insect/tick bites?    If yes, when \_\_\_\_\_

Caffeine     Yes     No    Do you drink coffee or tea?    If yes, how many cups per day: \_\_\_\_\_  
 Yes     No    Do you drink soda with caffeine?    If yes, how many cans per day \_\_\_\_\_

Smoking     Yes     No    Do you smoke cigarettes?    Age started \_\_\_\_\_    If yes, how many packs per day? \_\_\_\_\_  
 Yes     No    Did you smoke cigarettes?    Age started \_\_\_\_\_    If yes, how many packs per day? \_\_\_\_\_    Age you stopped? \_\_\_\_\_  
 Yes     No    Do you smoke anything else besides cigarettes?    If yes, what? \_\_\_\_\_

Alcohol     Yes     No    Do you drink alcohol?    If yes:  Beer     Wine     Hard liquor    Drinks per day? \_\_\_\_\_  
 Yes     No    Has anyone ever told you To drink less alcohol?  
 Yes     No    Do you use drugs for recreational purposes?  
 Yes     No    Have you ever injected drugs?

Driving     No     Yes    Are you able to drive?  
Sleep     No     Yes    Do you get enough sleep at night?    How many pillows do you use? \_\_\_\_\_  
 No     Yes    Do you feel rested when you wake up?    What time do you:    Go to bed? \_\_\_\_\_  
 No     Yes    Is it easy for you to:    Go to sleep?    What time do you:    Go to sleep? \_\_\_\_\_  
 No     Yes    Is it easy for you to:    Stay asleep?    What time do you:    Wake up in the morning? \_\_\_\_\_  
 No     Yes    Is it easy for you to:    Obtain restful sleep?    What time do you:    Get out of bed? \_\_\_\_\_

**MEDICATIONS**

**Drug Allergies**

Do you have any allergies to medications?     Yes     No    If yes, to what:

Type of reactions \_\_\_\_\_

**CURRENT MEDICATIONS: What Medications are you taking now?**

List ALL medications you are taking, prescription and non prescription. Non prescription items include aspirin, ibuprofen, naproxen, vitamins, laxatives, supplements (calcium, iron, etc.), herbs, etc. Indicate the dose (strength of the pill and number of pills per day), whether it is helpful, and whether you have had any bad reactions or discomfort from the medicine (we sometime call these problems "side effects").

Name of Medication	Dose	Pills daily	Start Date	Reason using	Does it help	Reactions to the medication

**PAST ARTHRITIS MEDICATIONS: The following is a list of many arthritis and other medications. Please CIRCLE each medication you have taken**

<b>Pain / NSAIDS</b>	<b>NSAIDs...</b>	<b>Corticosteroids</b>	<b>“Anti-Rheumatic Drugs...”</b>	<b>Biologics-BRM, Cont..</b>	<b>Muscle Relaxants</b>	<b>Anti-depressant</b>
Advil (Ibuprofen) Aspirin Tylenol Tylenol with Codeine	Ansaid Duexis Celebrex Clinoril Daypro Dolobid Feldene	Cortisone Medrol Prednisone Prednisolone <b>Gout Medicines</b> Allopurinol Benemid Colcrys Colchicine	Olumiant Otezla Imuran Methotrexate pills Methotrexate shots  Penicillamine Plaquenil Rasuvo Rinvoq Xeljanz <b>Biologics-BRMs</b> Actemra Cimzia	Rituxin Simponi Stelara Taltz Tremfya <b>Stomach/Anti-ulcers</b>  Antacids Aciphex Axid Carafate Cytotec Dexilant Nexium	Flexeril Norflex Parafon forte Robaxin Soma Skelaxin  Zanaflex <b>Osteoporosis</b> Actonel Atelvia Boniva Calcitonin Didronel Evenity	Celexa Cymbalta Desaryl Effexor Elavil Lexapro  Paxil Pristiq Prozac Serzone Sinequan Savella Tofranil Zoloft
Vicodin Hydrocodone Norco	Indocin Lodine Meclomen	Arava  Krystexxa Mitigare Uloric	Cosentyx Enbrel	Pepcid Prevacid	Evista Forteo	<b>Sleep</b> Ambien
Disalcid	Mobic Motrin Nalfon Naproxyn Orudis	Cyclosporine Cytoxan Gold shots or Gold Pills(Ridaura) Cellcept	Humira Kevzara Kineret	Prilosec Protonix	Fosamax Miacalcin Prolia Reclast Teriparatide Tymlos	Lunesta Sonata Rozerem
Lyrica Neurontin	Oruvail Relafen		Orencia Remicade →	Tagamet Zantac		Dalmane Halcion Restoril

**For each medication circled above (and any other arthritis medication not listed), please do the following**

Name of Medication	Dose: Strength of Pill	Pills per day	Start Date	Stop Date	Did it help?	Reason stopped	Reactions to the medication
					1. No 2. A little 3. A lot	1. Did not work 2. Stopped working 3. Did not need 4. Side effects	1. Stomach upset 2. Bleeding ulcer 3. Kidney 4. Liver 5. Lung 6. Skin 7 Other



**REVIEW OF SYSTEMS:** Check which symptoms apply to you; please complete any blanks.

**GENERAL**

- Fatigue  
Chronic  Yes  No  
Recent  Yes  No
- Weakness  
Generalized  Yes  No  
Local  Yes  No  
Where? \_\_\_\_\_
- Fever  Yes  No  
High?  Yes  No  
How often? \_\_\_\_\_
- Recent weight change  Yes  No  
How much? \_\_\_\_\_  Gain  Loss
- Loss of appetite  Yes  No  
Thirst  Yes  No

**SKIN**

- Bruise easily  Yes  No  
Rash  Yes  No  
Redness  Yes  No  
Hives  Yes  No
- Tightness  Yes  No  
Hair loss  Yes  No  
Dry  Yes  No  
Nodules/Bumps  Yes  No
- Sensitive or allergic to sunlight  Yes  No  
Hands/feet change color in cold  Yes  No  
Increased pigmentation  Yes  No  
Decreased pigmentation  Yes  No  
Ulcerations (sores)  Yes  No

**EARS**

- Ringing in ears  Yes  No  
Hearing loss/impaired  Yes  No

**EYES**

- Painful  Yes  No  
Red  Yes  No  
Dry  Yes  No  
Loss/impaired vision  Yes  No  
Double or blurred vision  Yes  No  
Feels like something in eye  Yes  No

**NOSE**

- Nosebleeds  Yes  No  
Loss/impaired of smell  Yes  No  
Dry  Yes  No

**MOUTH**

- Sore tongue  Yes  No  
Gums bleed  Yes  No  
Sores in mouth  Yes  No  
Loss/impairment of taste  Yes  No  
Dry  Yes  No  
Yeast in mouth  Yes  No

**THROAT**

- Frequent sore throats  Yes  No  
Hoarse  Yes  No  
Hard to swallow  Yes  No

**NECK**

- Swollen glands  Yes  No  
Tender glands  Yes  No

**HEART and LUNGS**

- Chest pain  Yes  No  
Heart murmur  Yes  No  
Irregular heart beat  Yes  No  
Sudden changes in heart beat  Yes  No
- Shortness of breath  Yes  No  
Wheezing  Yes  No  
Difficulty breathing at night  Yes  No  
Cough up blood  Yes  No  
Coughing  Yes  No
- Swollen legs, ankles or feet  Yes  No  
High blood pressure  Yes  No  
Night sweats  Yes  No

**STOMACH and INTESTINES**

- Nausea  Yes  No  
Heartburn  Yes  No  
Indigestion  Yes  No  
Stomach pain relieved by food, milk or antacids.  Yes  No  
Blood in stools  Yes  No  
Black stools  Yes  No  
Vomit blood or coffee ground-like material  Yes  No
- Jaundice/yellow skin  Yes  No  
Constipation  Yes  No  
Diarrhea  Yes  No

**KIDNEY/URINE/BLADDER/GENITALS**

- Have difficulty trying to urinate  Yes  No  
Pain or burning when urinating  Yes  No
- Blood in urine  Yes  No  
Pus in urine  Yes  No  
Urine is cloudy or "smoky"  Yes  No

- Discharge from penis or  Yes  No  
Have to urinate frequently  Yes  No  
Must get up at night to urinate  Yes  No

- Vaginal dryness  Yes  No  
Genital rash/ulcers  Yes  No  
Herpes  Yes  No

- Prostate problems  Yes  No  
Sexual activities limited  Yes  No  
By disease  Yes  No  
Other reasons  Yes  No

**BLOOD**

- Anemia  Yes  No  
Bleeding tendency  Yes  No

**NERVOUS SYSTEM**

- Headaches/Where  
Front of head  Yes  No  
Back of head  Yes  No
- Dizziness/When  
All the time  Yes  No  
When changes positions  Yes  No  
Fainting  Yes  No  
Loss of consciousness  Yes  No  
When? \_\_\_\_\_
- Memory loss – can't remember  
Recent activity  Yes  No  
Old events  Yes  No

- Muscle spasm  
Generalized  Yes  No  
Localized  Yes  No  
Where? \_\_\_\_\_

- Sensitivity or pain due to cold  
In hands  Yes  No  
In feet  Yes  No

- Numbness/tingling  
Hands  Yes  No  
Arms  Yes  No  
Feet  Yes  No  
Legs  Yes  No  
Coordination problems  Yes  No

- Do you have difficulty  
Relaxing  Yes  No  
Concentrating  Yes  No  
Deciding things  Yes  No
- Are you: Nervous  Yes  No  
Depressed  Yes  No  
Worried a lot  Yes  No  
Losing your temper  Yes  No  
Anxious  Yes  No

**MENSTRUAL HISTORY**

[ ] N/A, male

Age periods began \_\_\_\_\_ Lasting how long \_\_\_\_\_ Days apart \_\_\_\_\_

Age periods ended \_\_\_\_\_

Month/year of: Last Menstrual period \_\_\_\_\_

Month/year of: Last bleeding of any kind \_\_\_\_\_

- Yes  No Do you consider yourself postmenopausal. If yes, was it
  - Natural menopause  Surgical menopause (hysterectomy)
  - Yes  No Were one or more ovaries removed?
- Yes  No Are/were your periods regular  
Were your periods infrequent or absent:
- Yes  No For one or more years
- Yes  No Because of athletic participation (running, gymnastics, diving, etc.)

- Yes  No Have you ever used contraception. If yes, describe:  
Current: \_\_\_\_\_  
Past: \_\_\_\_\_
- Yes  No Have you ever taken estrogen therapy (ERT/HRT)?  
If yes, date started: \_\_\_\_\_ Date stopped: \_\_\_\_\_  
If no, why not? \_\_\_\_\_  
Current ERT/HRT: \_\_\_\_\_  
List all previous ERT/HRT: \_\_\_\_\_  
\_\_\_\_\_  
If you stopped, ERT/HRT, why?  
\_\_\_\_\_

**OSTEOPOROSIS PROFILE QUESTIONS**

Sex/Race:  Female  Male  White  Asian  Hispanic  Black  Other :

Age/Ancestry: Age \_\_\_\_\_  N Europe  Scotch  Irish  English

Height Changes: Maximum Height: \_\_\_\_\_ Height today: \_\_\_\_\_

Weight Changes: Weight at 20: \_\_\_\_\_ At 50 \_\_\_\_\_ Today \_\_\_\_\_

- Yes  No Have you been told you have osteoporosis?
- Yes  No Have you been told your x-ray shows low bone mass?
- Yes  No Have you ever had a bone density study? If yes, was it:
  - Spine  Hip  Wrist  Ankle
  - When: \_\_\_\_\_ Where: \_\_\_\_\_
- Yes  No Have you ever had a CT scan of your spine or hip
- Yes  No Have you broken any bones? Which ones:
  - Spine  Hip  Wrist  Ankle
  - Rib  Toe  Other \_\_\_\_\_
- Yes  No Have you taken any of the medicines below? Which ones:
  - Fosamax  Actonel  Evista  ERT/HRT
  - Calcitonin  Fluoride  Didronel
- Yes  No Do you have a family history of osteoporosis?
  - Mother  Daughter  Sister  Grandmother
  - Father  Son  Brother  Grandfather
- Yes  No Did any family members with osteoporosis have a fracture?
  - Mother  Daughter  Sister  Grandmother
  - Father  Son  Brother  Grandfather
- Yes  No Do you have scoliosis (curvature of the spine)?
- Yes  No Do you have any of these physical characteristics?
  - Petite/small build (8 or less dress/36 or less jacket)
  - Light hair, fair skin, freckles when young
- Yes  No Are you/have you been inactive, immobile or confined indoors?
- Yes  No Do you have/did you have an eating disorder?
  - Anorexia  Bulimia  Other
- Yes  No Do you/did you smoke more than 1 pack /cigarettes day?
- Yes  No Do you/did you drink 2 or more alcohol beverages a day?
- Yes  No Do you/did you drink 2 or more caffeine beverages a day?
- Yes  No Was your dairy product use limited for any reason?
  - Allergic  Caused cramps or stomach upset
  - Consumed 2 or less milk products day
- Yes  No Do you/did you taken any of the following medications:
  - Prednisone/Medrol  Dilantin
  - Chemotherapy  Heparin/Coumadin
  - Methotrexate  Lupron
  - Thyroid supplements  Lithium
- Yes  No Do you/did you have any of the following health problems:
  - Gastric surgery  Asthma
  - Epilepsy  Breast Cancer
  - Rheumatoid arthritis  GI/Bowel disease
  - Liver problems  Prostate cancer
  - Thyroid supplements  Infertility
  - Kidney diseases  Malabsorption syndrome
  - Juvenile diabetes  Transplant recipient
- No  Yes Did you breast feed any children?
- No  Yes Do you take calcium supplements?
- No  Yes Do you take a multivitamin or Vitamin D supplement?
- No  Yes Are you physically active?
  - Jog  Walk frequently  Swim  Other