ARTHRITIS CENTER

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Welcome to the medical practice of Doctors Karen Zagar, Tatiana Nagibina, Priya Sadanandan and Gina Raptoulis. The Arthritis Center focuses on performing to the highest standard, **YOUR SATISFACTION.** Our objective is to provide you with an excellent medical experience.

Enclosed you will find a Patient Information Sheet, a HIPAA Form and a Medical History Form. Please have these forms filled out and bring these forms plus any X-RAY and /or lab work pertaining to this visit with you the day of your appointment. These records are very important to your diagnosis and treatment if you are being referred to us because of an abnormal blood test or bone density test. We will also need a **photo ID and your insurance card(s).** All co-pays and deductibles are due at the time of service.

If you have questions, please do not hesitate to contact our office. Please plan to arrive 10 minutes early for your first appointment so that we can process the paperwork.

Sincerely,

Karen Zagar, M.D.

Tatiana Nagibina, M.D.

Priya Sadanandan, M.D.

Gina Raptoulis, D.O.

And The Staff of Arthritis Center

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of the Arthritis Center's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

PATIENT INFORMATION Date_____

Patient Name_____

Address_____City_____State_____Zip_____

Primary Phone_____Secondary Phone_____

Secondary Address_____

DOB_____ Social Security Number _____

Marital Status: S M D W Sex: M / F Height _____ Weight_____

Race: American Indian Asian Black Caucasian Pacific Islander Other

Ethnicity: Hispanic or Non-Hispanic Primary Language: _____

E Mail Address_____@_____Employer_____

Emergency ContactName_____Phone_____

Secondary Address_____City_____State_____Zip_____

Referring Physician _____Phone_____ Fax_____

Primary Care Physician_____ Phone_____

Address_____City_____State_____Zip_____

*Your Pharmacy*_____Tel #(__)_____

Address_____City_____State_____Zip_____

ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS, INCLUDING MEDICARE, IF I AM A MEDICARE BENEFICIARY, BE MADE ON MY BEHALF TO ARTHRITIS CENTER, INC FOR ANY EQUIPMENT OR SERVICES PROVIDED TO ME BY THAT ORGANIZATION.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE IMMEDIATELY OF ANY CHANGE IN MY INSURANCE COVERAGE. ON NON-ASSIGNED CLAIMS, I AM FINANCIALLY RESPONSIBLE FOR ALL FEES INCURRED ON MY BEHALF FOR ANY SERVICE FURNISHED TO ME. ON ASSIGNED CLAIMS, I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE, CO-PAYMENT, OR DEDUCTIBLES NOT COVERED BY MY INSURANCE. I FURTHER AGREE TO PAY ANY LEGAL OR OTHER FEES INCURRED IN THE COLLECTION OF ANY DELINQUENT CHARGES FOR WHICH I AM FINANCIALLY RESPONSIBLE.

X_____

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH ARTHRITIS CENTER, INC INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

X_____

The Arthritis Center Patient History Form

Date of first appointment: ____/____/____ Time of appointment:_____ Birthplace: _____
MONTH DA Y YEAR

Name:_____ Birthdate:____/__/____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address:_____ Age:_____ Sex: ☐ F ☐ M
STREET APT#

_____Telephone: Home (____)_____
CITY STATE ZIP 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)

_____

_____

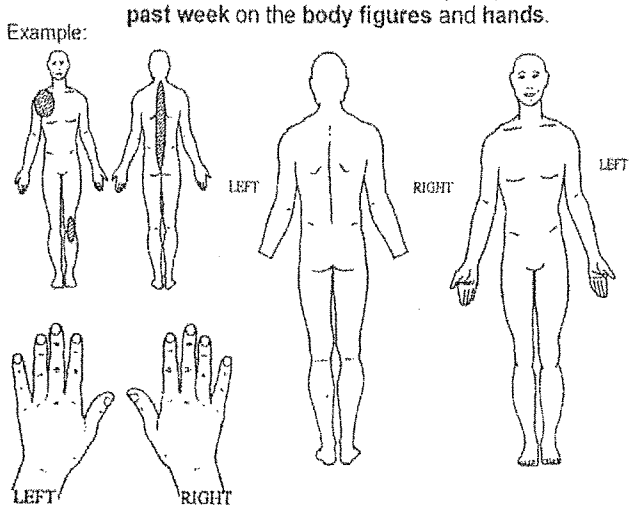
_____

Please list the names of other practioners you have seen for this problem

_____

_____

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



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:					

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 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

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?_____

_____

Type of reaction:_____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

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

PAST MEDICATIONS 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 ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/dosage	Length of time	Helped a lot, somewhat, or not at all.	Reactions
Non-Steroidal Anit-Inflammatory Drugs			
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulinda Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac) Mobic			
Pain relievers			
Acetaminophen (Tylenol)			
Codeine (Vicodin, Tylenol 3)			
Propoxyphene (Darvon/Darvocet)			
Other:			
Other:			
Disease Modifying Antirheumatic Drugs (DMARDS)			
Auranofin, gold pills (Ridaura)			
Gold shots (Myochrysine or Solganol)			
Hydroxychloroquine (Plaquenil)			
Penicillamine (Cuprimine or Depen)			
Methotrexate (Rheumatrex)			
Azathioprine (Imuran)			
Sulfasalazine (Azulfidine)			
Quinacrine (Atabrine)			
Cyclophosphamide (Cytoxan)			
Cyclosporine A (Sandimmune or Neoral)			
Enbrel			
Remicade			
Prosorba Column			
Humira			
Other:			

PAST MEDICATIONS Continued

Osteoporosis Medications			
Estrogen (Premarin, etc.)			
Alendronate (Fosamax)			
Etidronate (Didronel)			
Raloxifene (Evista)			
Fluoride			
Calcitonin injection or nasal (Miacalcin, Calcima			
Risedronate (Actonel)			
Other:			
Other:			
Gout Medications			
Probenecid (Benemid)			
Colchicine			
Allopurinol (Zyloprim/Lopurin)			
Other:			
Other:			
Others			
Tamoxifen (Nolvadex)			
Tiludronate (Skelid)			
Cortisone/Prednisone			
Hyalgan/Synvisc injections			
Herbal or Nutritional Supplements			
Please list supplements:			

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, please list: _____

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 (Type:_____) ❑ Asthma ❑ Goiter

❑ Heart problems (Type: _____) ❑ Stroke ❑ Psoriasis

❑ Kidney disease(Type: _____) ❑ Leukemia

❑ Cataracts ❑ Diabetes ❑ Epilepsy

❑ Anxiety/Depression ❑ Stomach ulcers ❑ Rheumatic fever

❑ Jaundice ❑ Colitis ❑ Pneumonia

❑ 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
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
Mother				
Father				

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_____