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www.arthritiscenter.org

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 Contact Name _____ 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 DAY 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: _____

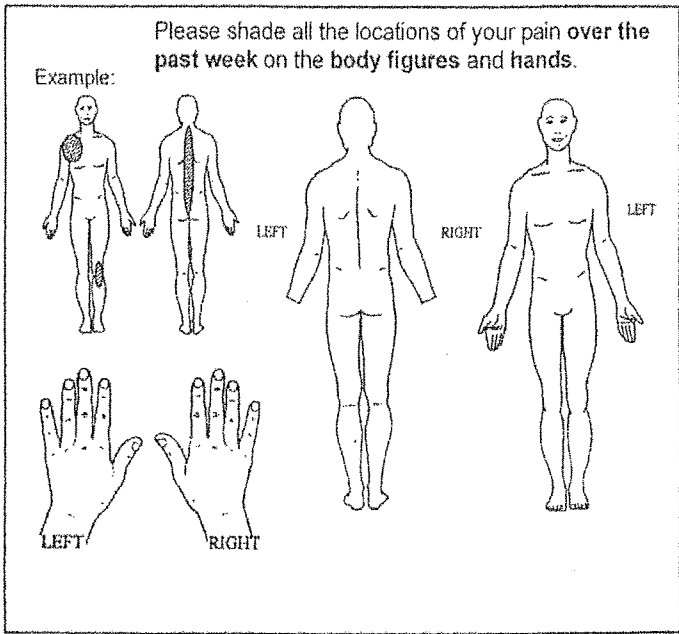
Describe briefly your present symptoms: _____

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



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yoursel	Relative:Name/Relationship	Yoursel	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	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 Anti-Inflammatory Drugs			
<p>Circle any you have taken in the past</p> <p> Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) 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 </p>			
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, Calcimar)			
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 _____