Welcome to Arthritis Center which focuses on performing to the highest standard, **YOUR SATISFACTION**. Our objective is to provide you with one of the best medical experiences that you have ever had.

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

We do realize that the wait to be seen in our office can be quite lengthy. We try to accommodate each person as best as we can. If for any reason you can not make your appointment with us, please contact our office a minimum of 24 hours before your scheduled appointment as a courtesy to us and to others wanting to be seen.

If you have questions, please do not hesitate to contact our office. Please arrive **15 minutes early** for your first appointment, so that we can process the paperwork. If you arrive late, or without the paperwork, **your appointment will be rescheduled to another day**.

Sincerely,

Karen E. Zagar, M.D.

Tatiana Nagibina, M.D.

Elaine Greifenstein, M.D.

And The Staff of Arthritis Center
Physician you are scheduled to see: ________________________________

PATIENT INFORMATION                        Date: __________________

Patient Name: ________________________________

Address: __________________ City: __________________ State: ___ Zip: ___

Primary Phone: __________________ Secondary Phone: __________________

Secondary Address: __________________

DOB: __________________ Social Security Number: __________________

Circle One:     Marital Status:  S  M  D  W

Race: American Indian  Asian  Black  Caucasian  Pacific Islander  Other

Primary Language: ______________  E Mail: ______________@____________

Emergency Contact Name: __________________ Phone: __________________

Referring Physician: __________________ Phone: __________________

Primary Care Physician: __________________ Phone: __________________

Your Pharmacy: __________________ Phone: __________________

MEDICAL INSURANCE INFORMATION REQUIRED:

PRIMARY  INSURANCE COMPANY NAME: __________________ POLICY#: __________________

SECONDARY INSURANCE (SUPPLEMENT) COMPANY NAME: __________________

POLICY#: __________________

CANCELLATION / NO SHOW POLICY

NO SHOW OR SAME DAY CANCELLATIONS WILL BE ASSESSED A $50 FEE. CANCELLATIONS NEED TO BE MADE PRIOR TO 24 HOURS OF YOUR SCHEDULED APPOINTMENT TIME.

X __________________

ASSIGNMENT OF BENEFITS

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

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 __________________
Welcome to Arthritis Center. Please read the following for your financial obligation. You understand and agree that you are responsible and liable for payment of all charges for professional services rendered. If our office is participating with your insurance and accepts assignment, this means that we will accept what your insurance allows for the services performed which is less than our standard billed amount. Based on your plan, our office will collect the designated copay or the co-insurance estimated patient responsibility amount at the time of your visit. Once your claim processes through your insurance, the patient responsibility may be more or less than the original estimated amount. You will receive a statement in the mail if there is a balance owed by you that will be due upon receipt. If you have a credit, our office will apply that credit to any open patient balances on your account. It is our office policy to hold all credits on your account until all open claims have been processed by your insurance company.

You authorize payment of medical benefits to the physician/care center performing the professional services. In the event your insurance company forwards payment directly to you, you will deliver such payment to the Arthritis Center.

**PRIVATE PAY:** Full payment is expected when services are rendered if patient is not using health insurance. We accept cash and most major credit/debit cards. Personal checks are not accepted for self-pay patients.

**PPO’s & HMO’s:** You are responsible for any copays, deductible, co-insurances, and non-covered services.

**It is the patient’s responsibility to verify any required authorizations/referrals are in place prior to their visit**

**Medicare:** We are Medicare providers and accept Medicare assignment. You are responsible for the Medicare yearly deductible, co-insurance, and non-covered services. We will also file your secondary insurance as courtesy. If your secondary insurance does not make payment, you are responsible for this balance. We do not bill tertiary plans, this is the patient’s responsibility.

**Medicaid:** We do not participate with ANY Medicaid. The patient is responsible for payment if you have Medicaid. If you have Medicaid as a SECONDARY plan, we will agree to write off the 20% that the primary plan does not cover after completion of a hardship form with our business office.

**Litigation/Attorney:** Our office does NOT accept Worker’s Compensation, Auto/Personal injury cases, nor do we accept Letters of Protection.

You are responsible for keeping our office informed of any changes in your insurance company or plan. If you fail to inform us of a change and the wrong insurance is billed, you will be responsible for the balance and billing to the new plan.

By signing below, you are stating you understand and agree to all of the above terms and policies:

“I understand that I am ultimately responsible for all charges incurred regardless of my existing medical coverage. I accept responsibility for all patient balances due according to the above terms. Should my account become past due, the full balance is due and payable immediately. I will be responsible for all collection and legal costs incurred for collecting the delinquent on my account.”

________________________________________  __________________________________________  ______________
Patient Signature                       Patient Printed Name                       Date
HIPAA Notice of Privacy Practices

Karen E. Zagar, M.D.
Tatiana Nagibina, M.D.
Elaine Greifenstein, M.D.
32615 US HWY 19 N., SUITES 2 & 3
Palm Harbor, FL 34684
727-789-2784

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information ( PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.
Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.
Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS**
The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.
ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given 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

Provide By HCSI
STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PHI

ARTHRTIS CENTER
32615 US HIGHWAY 19 NORTH STE 2 & 3
PALM HARBOR, FL 34684

Information to be Used or Disclosed
The information covered by this authorization includes: (check one)
☐ All Health Information ☐ Limited To (e.g. All but my lab results) ______________________________________

Purpose of the Disclosure: Assistance in Care

Persons Authorized to Use or Disclose the Above Information: ARTHRITIS CENTER, INC

Persons to Whom Information May Be Disclosed (e.g. Caregiver, Spouse, Child):

(Name of person or organization)

Expiration Date of Authorization
This authorization is effective through (check one) ☐ __/__/____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient’s personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

Name of patient (Type/Print)

Signature of Patient Date

Signature of Patient Representative (if applicable)

Relationship of Patient Representative to Patient (if applicable) Provided By HCSI
The Arthritis Center Patient History Form

Date of first appointment: _____/___/____ Time of appointment:_______ Birthplace: ____________________________

Name: ____________________________ Birthday: _____/___/____

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 practitioners you have seen for this problem

_____________________________________________________________________________________________

_____________________________________________________________________________________________

RHEUMATOLOGIC HISTORY

At any time have you or a blood relative had any of the following? (Check if “yes”)

<table>
<thead>
<tr>
<th>Yourself</th>
<th>Relative: Name/Relationship</th>
<th>Yourself</th>
<th>Relative Name/Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis (unknown type)</td>
<td></td>
<td>Lupus or “SLE”</td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td></td>
<td>Rheumatoid Arthritis</td>
<td></td>
</tr>
<tr>
<td>Gout</td>
<td></td>
<td>Ankylosing Spondylitis</td>
<td></td>
</tr>
<tr>
<td>Childhood arthritis</td>
<td></td>
<td>Osteoporosis</td>
<td></td>
</tr>
</tbody>
</table>

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 bone densitometry (DEXA) ___/___/_______

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.)

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>Dose (include strength and # of pills per day)</th>
<th>Reason for Medication (Diagnosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
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<tr>
<td>7.</td>
<td></td>
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<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Drug names/dosage</th>
<th>Length of time</th>
<th>Helped a lot, somewhat, or not at all.</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Steroidal Anti-Inflammatory Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circle any you have taken in the past</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ansaid (flurbiprofen)</td>
<td>Arthrotec (diclofenac + misoprostol)</td>
<td>Aspirin</td>
<td>Celebrex (celecoxib)</td>
</tr>
<tr>
<td>Daypro (oxaprozin)</td>
<td>Disalcid (salsalate)</td>
<td>Dolobid (diflunisal)</td>
<td>Feldene (piroxicam)</td>
</tr>
<tr>
<td>Meclomen (meclomenamate)</td>
<td>Lodine (etodolac)</td>
<td>Mobic</td>
<td>Motrin (ibuprofen)</td>
</tr>
<tr>
<td>Tolectin (tolectin)</td>
<td>Naprosyn (naproxen)</td>
<td>Oruvail (ketoprofen)</td>
<td>Trilisane (choline magnesium trisalicylate)</td>
</tr>
<tr>
<td>Vioxx (rofecoxib)</td>
<td>Voltaren (diclofenac)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain relievers</th>
<th>Length of time</th>
<th>Helped a lot, somewhat, not at all</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td></td>
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</tr>
<tr>
<td>Codeine (Vicodin, Tylenol 3)</td>
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<tr>
<td>Tramadol</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Disease Modifying Antirheumatic Drugs (DMARDS)**

| Actemra |                |                                    |           |
| Azathioprine (Imuran) |            |                                    |           |
| Cimzia |                |                                    |           |
| Cyclophosphamide (Cytoxan) |            |                                    |           |
| Cyclosporine A (Sandimmune or Neoral) |            |                                    |           |
| Enbrel |                |                                    |           |
| Humira |                |                                    |           |
| Hydroxychloroquine (Plaquenil) |            |                                    |           |
| Kezvra |                |                                    |           |
| Kineret |               |                                    |           |
| Methotrexate (Rheumatrex) |            |                                    |           |
| Olumiant |             |                                    |           |
| Remicade/Inflectra |            |                                    |           |
| Rituxan |                |                                    |           |
| Sulfasalazine (Azulfidine) |            |                                    |           |
| Simponi/Simponi Aria |            |                                    |           |
| Xeljanz |                |                                    |           |
| Other: |                |                                    |           |
## PAST MEDICATIONS Continued

<table>
<thead>
<tr>
<th>Osteoporosis Medications</th>
<th>Length of time</th>
<th>Helped a lot, somewhat not at all</th>
<th>Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen (Premarin, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alendronate (Fosamax)</td>
<td></td>
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<tr>
<td>Etidronate (Didronel)</td>
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<td></td>
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<tr>
<td>Raloxifene (Evista)</td>
<td></td>
<td></td>
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<tr>
<td>Fluoride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcitonin injection or nasal (Miacalcin, Calcimar)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risedronate (Actonel)</td>
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<td>Prolia or Evenly</td>
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<tr>
<td>Reclast (Zoledronic Acid)</td>
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<tr>
<td><strong>Gout Medications</strong></td>
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<tr>
<td>Probenecid (Benemid)</td>
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<tr>
<td>Colchicine</td>
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<tr>
<td>Allopurinol (Zyloprim/Lopurin)</td>
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<tr>
<td>Krystexxa</td>
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<tr>
<td>Other:</td>
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<tr>
<td><strong>Others</strong></td>
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<tr>
<td>Tamoxifen (Nolvadex)</td>
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<tr>
<td>Tildronate (Skelid)</td>
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<tr>
<td>Cortisone/Prednisone</td>
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<tr>
<td>Hyalgan/Synvisc injections</td>
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<tr>
<td>Herbal or Nutritional Supplements</td>
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<tr>
<td>Please list supplements:</td>
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</tbody>
</table>

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? Yes ☐ No ☐ Past – How long ago? ______
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
☐ Heart problems (Type: ______) ☐ Stroke ☐ Psoriasis
☐ Kidney disease (Type: ______) ☐ Leukemia
☐ Thyroid problems (Type: ______) ☐ Goiter
☐ 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

<table>
<thead>
<tr>
<th>Type</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>6.</td>
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<td>7.</td>
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</tbody>
</table>

Any previous fractures? Yes ☐ No ☐
Describe: _______________________________________________________

Any other serious injuries? Yes ☐ No ☐
Describe: _______________________________________________________

FAMILY HISTORY:

<table>
<thead>
<tr>
<th></th>
<th>If Living</th>
<th>If Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Health</td>
<td></td>
<td>Age at Death</td>
</tr>
<tr>
<td>Cause</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<tr>
<td>Father</td>
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</tbody>
</table>

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___________ ☐ Broken Hip__________