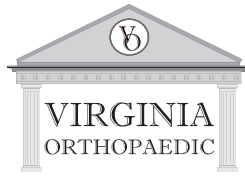


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Lynn S. Gilbert, PA-C, AAPA, VAPA

Date \_\_\_\_\_

PLEASE PRINT

Home Phone \_\_\_\_\_

### Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single Married Widowed Separated Divorced

Patient employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

### Primary Insurance

Person responsible for account \_\_\_\_\_

Last Name First Name Initial

Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person responsible employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

### Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber name \_\_\_\_\_ Relation to patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

### Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

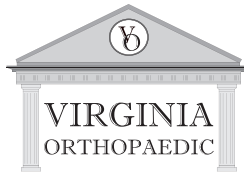
and assign directly to **Virginia Orthopaedic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

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## AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS

### LIFETIME FORM

**PATIENT'S NAME:** \_\_\_\_\_

**SUBSCRIBER'S NAME:** \_\_\_\_\_

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Virginia Orthopaedic P.C., for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or their insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services.

**SUBSCRIBER'S SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO MY REFERRING PHYSICIAN.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO ANY PHYSICIAN OR OTHER HEALTH CARE PROVIDER TO WHOM I AM REFERRED BY MY PHYSICIAN.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



# AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

## 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#

\_\_\_\_\_  
CITY STATE ZIP Telephone: Home (\_\_\_\_\_) \_\_\_\_\_  
 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): \_\_\_\_\_ **Example**

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:

\_\_\_\_\_  
 \_\_\_\_\_

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

Example:

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

**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
<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
- Vomiting of blood or coffee ground material
- Stomach pain 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

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

**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  Heart problems  Asthma  
 Goiter  Leukemia  Stroke  
 Cataracts  Diabetes  Epilepsy  
 Nervous breakdown  Stomach ulcers  Rheumatic fever  
 Bad headaches  Jaundice  Colitis  
 Kidney disease  Pneumonia  Psoriasis  
 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	Reason
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
Father				
Mother				

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 \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

**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 & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Circle any you have taken in the past</b> Ansaid (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)					
<b>Pain Relievers</b>					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosurba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_  
 Patient History Form © 1999 American College of Rheumatology

**PAST MEDICATIONS Continued**

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

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

If yes, list:

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Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

