**Department of**
**Internal Medicine**
**University Rheumatologists**
*The Rush Arthritis and*
*Orthopedic Institute*

1611 West Harrison Street
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**RUSH UNIVERSITY**
COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE

RUSH UNIVERSITY MEDICAL CENTER

Dear Patient,

Welcome to University Rheumatologists. We are located at 1611 West Harrison Street, Suite 510 of the Orthopedic Building at Rush University Medical Center. Directions have been included for your convenience. Parking is available at the garage on the corner of Paulina and Harrison Street. If you park in this garage we are able to validate your ticket for a discounted rate, please inquire at our front desk. Valet parking is also available in the front of the Orthopedic Building but not at a discounted rate.

Please arrive 15 minutes prior to your appointment time to complete the registration process. Rush University Medical Center provides interpretive services when advance notice is given. If you require an interpreter, or need to change or cancel an appointment please call us at 312-563-2800 and press 1. We request that you notify us of your change or cancellation no less than 24 hours in advance. A timely notification will permit patients that are waiting to schedule a sooner appointment. If you fail to notify us at least 24 hours prior to your appointment time, it may result in being discharged from the practice.

We want your visit with us to be a success. Therefore, we have included a checklist to help you prepare for our time together. Please bring the completed packet with you on your appointment date. This will reduce your registration time on the day of your visit.

Thank you for choosing University Rheumatologists. We look forward to seeing you and participating in your care.

Sincerely,

University Rheumatologists

# New Patient Checklist

**Prior to Your Visit:**

☐ **FAX Copies of medical records.** This includes physician progress notes, blood tests, x-ray reports or any other tests that might be of helpful to your doctor. Please send to Attention: NP Medical Records (Fax) 312-563-2075 or to the Address on the front of this packet. If unable to access a fax machine please bring the records with you to your visit

**Bring to Your Visit:**

☐ **A list of all current medications or the actual pill bottles (names, doses, frequency)**

☐ Please bring your current insurance card and photo ID to each visit.

☐ Your co-pay (look on your insurance card for amount) will be collected upon check-in at each visit. We accept cash, check, Visa, MasterCard, American Express and Discover credit cards.

- If you will not be using insurance, please be prepared to pay the full fee for services. A discount of 50% will be offered on the professional fee and 65% off the facility fee only if you pay in full on the same day service was provided.

☐ If you have a HMO/Managed care plan: Please obtain a referral prior to your visit from your primary care physician and bring it with you. The referral must be valid for the date of your appointment and should indicate the services authorized.

- Do you need a referral or authorization?

  ☐ Yes ☐ No

**Forms Attached (Please fill out and bring with you):**

☐ Authorization for release of patient health information. This is provided in case it is needed by outside facilities to send our office records. This can also be filled out to request records from our facility (that occurred prior to or on the signature date) to be sent elsewhere.

☐ Authorization for Use and Disclosure of Protected Health Information for Fundraising and Related Communication (*This form is optional).*

☐ Multi-Dimensional Health Assessment Questionnaire: Only the last 2 pages are included (3-4). Please fill these out prior to your appointment.

# New Patient Checklist

## PHARMACY

Retail Pharmacy

Name _____

Phone (  )_____

Address/Intersection

_____

_____

Mail-order Pharmacy (If Applicable)

Name _____

Phone (  )_____

Address/Intersection

_____

_____

## PHYSICIANS

Primary Care Physician

Name _____

Phone (  )_____

Address/Intersection

_____

_____

Physician that referred you today

☐Same as PCP

Name _____

Phone (  )_____

Address/Intersection

_____

_____

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

**Place Patient Label**

RUSH UNIVERSITY MEDICAL CENTER

# AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

HIM ROI Authorization
Authorization for Release of
Patient Health Information

IDN13151000

**INSTRUCTIONS:** This authorization is made by you for the release of your healthcare information, as indicated Please address questions about this form to: **Rush University Medical Center, ATTN: Health Information Management Office, 1611 West Harrison Street, L1, Suite 001, Chicago, IL 60612, Telephone: (312) 942-7262, Fax: (312) 942-2264.**

## SECTION 1: Patient Information

| Name [Last, First, MI] | | | | Date of Birth |
|---|---|---|---|---|
| Address [Street, City, State, Zip] | | | | |
| Phone Number(s):<br>Home | Cell | Business | Medical Record Number [if known] | Social Security Number (Last 4)<br>XXX-XX- ___ ___ ___ ___ |

## SECTION 2: Authorized to Request Use or Disclosure (FROM)

I request that my medical record information be sent **FROM** the person(s)/location(s) indicated below

| Name [Last, First, MI] | | | |
|---|---|---|---|
| Organization | | | |
| Address [Street, City, State, Zip] | | | |
| Phone Number(s):<br>Home | Cell | Business | Fax |

## SECTION 3: Authorized Recipient to Receive (TO)

I request that my medical record information be sent **TO** the person(s)/location(s) indicated below
If you are requesting **access to your own medical record**, please fill in your own personal information

| Name [Last, First, MI] | | | |
|---|---|---|---|
| Organization | | | |
| Address [Street, City, State, Zip] | | | |
| Phone Number(s):<br>Home | Cell | Business | Fax |

## SECTION 4: Purpose of the Use or Disclosure

The use or disclosure of my health information is requested for the following purposes (such as continuing care, attorney, self, employer, other):

## SECTION 5: Information to be Disclosed

The following type of information is authorized for release **[initial next to each type]** for the period of _____ to _____

| | |
|---|---|
| ☐ General Medical _____ | ☐ Substance Abuse _____ |
| ☐ HIV Records _____ | ☐ Mental Health and Developmental Disability Treatment Records _____ |
| ☐ Genetic Testing Records _____ | ☐ Other _____ |

RUSH UNIVERSITY MEDICAL CENTER

# AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

**Place Patient Label**

## SECTION 6: Disclosure to Include

This disclosure will include the following types of reports:

| | | | |
|---|---|---|---|
| ☐ X-Ray/Radiology Report | ☐ Operative Report | ☐ History and Physical | ☐ Pathology Report |
| ☐ Emergency Report | ☐ Consulting Report | ☐ Immunization Record | ☐ Itemized Bill |
| ☐ Progress/Physician Notes | ☐ Discharge Summary | ☐ EKG/EEG/EMG Report | |
| ☐ Films/Slides | ☐ Other: | | |
| ☐ Laboratory Report | | | |

## SECTION 7: Authorization Expiration Date

This authorization is approved for:

| | |
|---|---|
| ☐ This occurrence only | ☐ 60 days from the date of signature |

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use/or disclosure being authorized):

## SECTION 8: Please read the following statements carefully:

This authorization is voluntary. Rush will not condition your treatment on giving this authorization. However, Rush may condition the provision of research-related treatment on the provision of an authorization.

I understand that I may change my mind and revoke this authorization at any time by giving written notice of my revocation to the contact office listed above. I understand that revocation of this authorization will not affect action you took in reliance in this authorization before you received my written notice of revocation.

I authorize the use and/or disclosure of my Protected Health Information (PHI) as described above. I understand that this authorization is voluntary and made to confirm my decision so Rush may use and/or disclose my PHI for a specific purpose. I understand that, if the persons or organizations I authorized above to receive and/or use the PHI described above are subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed by Rush pursuant to the authorization may not be further disclosed except pursuant to my authorization.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the PHI described in this form.

## SECTION 9: Signature

| | |
|---|---|
| Patient Signature | Date |
| Personal Representative Name [Last, First, MI] | Personal Representative Phone Number |
| Personal Representative Relationship to Patient and Authority: | |
| Personal Representative Signature | Date |
| Witness Name [Last, First, MI] [Required for the release of mental health information] | Date |
| Witness Signature | Date |

## SECTION 10: Verification of Authority

How is the person's identity, authority, and relationship to the patient authorized?

| | |
|---|---|
| ☐ Personal Identification _____ | ☐ Personal representative status (identify as parent, guardian, executor, administrator, power of attorney) _____ |
| ☐ Government credentials _____ | ☐ Warrant, subpoena, order, summons, civil investigation, or other legal process _____ |
| ☐ Authority is known _____ | |

**Copy provided to the individual**

Department of Internal Medicine
University Rheumatologists
*The Rush Arthritis and Orthopedic Institute*
1611 W Harrison St , Suite 510
Chicago. IL 60612

Tel: 312 942 6641
Appt: 312 563 2800
Fax: 312 563 2075
www rush edu

RUSH

# Authorization for Use and Disclosure of Protected Health Information for Communications and Fundraising Opportunities

Patient's Name _____

Street Address _____

City/State/Zip _____

Phone _____ Birth Date: _____

E-mail _____

Physician/Practice _____

I authorize Rush University Medical Center (RUMC) to use and disclose the name of my physician and the name of the department in which I was treated. Information regarding my medical condition, diagnosis or treatment will not be disclosed.

I understand that this authorization will permit RUMC to provide me with relevant information on health care issues and programs through newsletters, publications, and other materials. In addition, I understand I may be contacted about opportunities to provide charitable support to RUMC in the areas pertaining to my personal health concerns.

RUMC fully supports the protection of health information. My name will not appear on any patient list that will be loaned or sold by RUMC or its medical practices nor will my name be used for telemarketing purposes.

My authorization is voluntary. My failure to sign this authorization will not affect my treatment, payment or eligibility for benefits in any way.

This authorization is valid until revoked. I may revoke this authorization at any time by submitting a request in writing to Rush University Medical Center, Philanthropy Office, 1700 W. Van Buren, Chicago, IL 60612. The revocation will be effective except to the extent that RUMC has already relied on my authorization.

_____

**Signature** *(patient or authorized representative)* **Date**

**For office use only:**
EPIC MR# _____

Approved by the Rush Privacy Office September 2011

# Multi-Dimensional Health Assessment Questionnaire (M801.51 NP4)

**This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.**

**1. Please check (√) the ONE best answer for your abilities at this time:**

| **OVER THE LAST WEEK,** were you able to: | Without **ANY** Difficulty | With **SOME** Difficulty | With **MUCH** Difficulty | **UNABLE** To Do |
|---|---|---|---|---|
| a. Dress yourself, including tying shoelaces and doing buttons? | 0 | 1 | 2 | 3 |
| b. Get in and out of bed? | 0 | 1 | 2 | 3 |
| c. Lift a full cup or glass to your mouth? | 0 | 1 | 2 | 3 |
| d. Walk outdoors on flat ground? | 0 | 1 | 2 | 3 |
| e. Wash and dry your entire body? | 0 | 1 | 2 | 3 |
| f. Bend down to pick up clothing from the floor? | 0 | 1 | 2 | 3 |
| g. Turn regular faucets on and off? | 0 | 1 | 2 | 3 |
| h. Get in and out of a car, bus, train, or airplane? | 0 | 1 | 2 | 3 |
| i. Walk two miles or three kilometers, if you wish? | 0 | 1 | 2 | 3 |
| j. Participate in recreational activities and sports as you would like, if you wish? | 0 | 1 | 2 | 3 |
| k. Get a good night's sleep? | 0 | 1.1 | 2.2 | 3.3 |
| l. Deal with feelings of anxiety or being nervous? | 0 | 1.1 | 2.2 | 3.3 |
| m. Deal with feelings of depression or feeling blue? | 0 | 1.1 | 2.2 | 3.3 |

**2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:**

NO PAIN ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

**3. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:**

| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| a. LEFT FINGERS | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | i. RIGHT FINGERS | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| b. LEFT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | j. RIGHT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| c. LEFT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | k. RIGHT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| d. LEFT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | l. RIGHT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| e. LEFT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | m. RIGHT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| f. LEFT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | n. RIGHT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| g. LEFT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | o. RIGHT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| h. LEFT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | p. RIGHT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| q. NECK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | r. BACK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

**4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:**

VERY WELL ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

**FOR OFFICE USE ONLY**

1.a-j FN (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2.PN (0-10):

4.PTGL (0-10):

RAPID 3 (0-30)

3.RADAI(0-48)

FAST3(0-3)

IDN13150147

**5. Please check (√) if you have experienced any of the following over the last month:**

| | | |
|---|---|---|
| ___Fever | ___Lump in your throat | ___Paralysis of arms or legs |
| ___Weight gain (>10 lbs) | ___Cough | ___Numbness or tingling of arms or legs |
| ___Weight loss (>10 lbs) | ___Shortness of breath | ___Fainting spells |
| ___Feeling sickly | ___Wheezing | ___Swelling of hands |
| ___Headaches | ___Pain in the chest | ___Swelling of ankles |
| ___Unusual fatigue | ___Heart pounding (palpitations) | ___Swelling in other joints |
| ___Swollen glands | ___Trouble swallowing | ___Joint pain |
| ___Loss of appetite | ___Heartburn or stomach gas | ___Back pain |
| ___Skin rash or hives | ___Stomach pain or cramps | ___Neck pain |
| ___Unusual bruising or bleeding | ___Nausea | ___Use of drugs not sold in stores |
| ___Other skin problems | ___Vomiting | ___Smoking cigarettes |
| ___Loss of hair | ___Constipation | ___More than 2 alcoholic drinks per day |
| ___Dry eyes | ___Diarrhea | ___Depression - feeling blue |
| ___Other eye problems | ___Dark or bloody stools | ___Anxiety - feeling nervous |
| ___Problems with hearing | ___Problems with urination | ___Problems with thinking |
| ___Ringing in the ears | ___Gynecological (female) problems | ___Problems with memory |
| ___Stuffy nose | ___Dizziness | ___Problems with sleeping |
| ___Sores in the mouth | ___Losing your balance | ___Sexual problems |
| ___Dry mouth | ___Muscle pain, aches, or cramps | ___Burning in sex organs |
| ___Problems with smell or taste | ___Muscle weakness | ___Problems with social activities |

**FOR OFFICE USE ONLY**

5. # SX: ☐

**Please check (√) here if you have had none of the above over the last month: _____.**

---

**6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes**
If "No," please go to Item 7. If "**Yes**," **please indicate the number of minutes**_____, **or hours** _____ until you are as limber as you will be for the day.

**7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.**
**M**uch **B**etter ☐ (1), **B**etter ☐ (2), the **S**ame ☐ (3), **W**orse ☐ (4), **M**uch **W**orse ☐ (5) than one week ago

**8. How often do you exercise aerobically** (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please check (✓) only one.**

☐ 3 or more times a week (3) ☐ 1-2 times per month (1)
☐ 1-2 times per week (2) ☐ Do not exercise regularly (0) ☐ Cannot exercise due to disability/ handicap (9)

**9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?**

| FATIGUE IS | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | FATIGUE IS A |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NO PROBLEM | 0 | 0.5 | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 4.5 | 5.0 | 5.5 | 6.0 | 6.5 | 7.0 | 7.5 | 8.0 | 8.5 | 9.0 | 9.5 | 10 | MAJOR PROBLEM |

**10. Over the last 6 months have you had: [Please check (√)]**

| | | | | | |
|---|---|---|---|---|---|
| ☐No | ☐Yes | An operation or new illness | ☐No | ☐Yes | Change(s) of arthritis or other medication |
| ☐No | ☐Yes | Medical emergency or stay overnight in hospital | ☐No | ☐Yes | Change(s) of address |
| ☐No | ☐Yes | A fall, broken bone, or other accident or trauma | ☐No | ☐Yes | Change(s) of marital status |
| ☐No | ☐Yes | An important new symptom or medical problem | ☐No | ☐Yes | Change job or work duties, quit work, retired |
| ☐No | ☐Yes | Side effect(s) of any medication or drug | ☐No | ☐Yes | Change of medical insurance, Medicare, etc. |
| ☐No | ☐Yes | Smoke cigarettes regularly | ☐No | ☐Yes | Change of primary care or other doctor |

**Please explain any "Yes" answer below, or indicate any other health matter that affects you:**

_____

_____

**11. Please list below any medications which you cannot take because you are allergic to them:**

_____ _____ _____ _____

**12. Please list below anything else (grass, molds, pollens, etc.) you might be allergic to:**

_____ _____ _____ _____

**13. Please check (✓) either "No" or "Yes" to indicate whether or not you have any of the conditions below:**

**Have you ever had:** **If you answer "Yes", please list AGE or YEAR when it began.**

| | | | AGE or YEAR | | | | AGE or YEAR |
|---|---|---|---|---|---|---|---|
| High Blood Pressure or Hypertension | ___No | ___Yes | _____ or _____ | Gynecological (Female)/ Prostate (Male) problem | ___No | ___Yes | _____ or _____ |
| Heart attack | ___No | ___Yes | _____ or _____ | Severe allergies | ___No | ___Yes | _____ or _____ |
| Other heart disease | ___No | ___Yes | _____ or _____ | Rheumatoid arthritis | ___No | ___Yes | _____ or _____ |
| Cancer | ___No | ___Yes | _____ or _____ | Osteoarthritis | ___No | ___Yes | _____ or _____ |
| Stroke | ___No | ___Yes | _____ or _____ | Lupus | ___No | ___Yes | _____ or _____ |
| Bronchitis or Emphysema | ___No | ___Yes | _____ or _____ | Back or spine problems | ___No | ___Yes | _____ or _____ |
| Asthma | ___No | ___Yes | _____ or _____ | Fibromyalgia (Fibrositis) | ___No | ___Yes | _____ or _____ |
| Other Lung problem | ___No | ___Yes | _____ or _____ | Osteoporosis | ___No | ___Yes | _____ or _____ |
| Anemia (Low Blood) | ___No | ___Yes | _____ or _____ | Broken bones after age 50 | ___No | ___Yes | _____ or _____ |
| Other hematologic problem | ___No | ___Yes | _____ or _____ | Dry mouth | ___No | ___Yes | _____ or _____ |
| Stomach ulcer | ___No | ___Yes | _____ or _____ | Dry eyes | ___No | ___Yes | _____ or _____ |
| Other gastrointestinal (GI) problem | ___No | ___Yes | _____ or _____ | Cataracts | ___No | ___Yes | _____ or _____ |
| | | | | Parkinson's disease | ___No | ___Yes | _____ or _____ |
| Thyroid problem | ___No | ___Yes | _____ or _____ | Depression | ___No | ___Yes | _____ or _____ |
| Diabetes | ___No | ___Yes | _____ or _____ | Mental illness | ___No | ___Yes | _____ or _____ |
| Kidney problem | ___No | ___Yes | _____ or _____ | Alcoholism | ___No | ___Yes | _____ or _____ |
| Other _____ (Please name) | | | _____ or _____ | Other _____ (Please name) | | | _____ or _____ |

**14. Please list below all operations you have ever had. Please check (✓) here if none: _____.**

| Operation | Year | Surgeon | Hospital, City, State |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

(You may continue below or on a separate page)

**15. Please list below all major illnesses or hospital admissions (other than for operations).**
**Please check (✓) here if none: _____.**

| Illness or Reason for hospitalization | Year | Hospital, City, State |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

(You may continue below or on a separate page)

**16. The questions below concern your family medical history:**

| | If Living | | If Deceased | |
|---|---|---|---|---|
| | Birth Year or Age | Any Major Medical Conditions | Year or Age at death | Cause(s) of death |
| Father | | | | |
| Mother | | | | |
| Brother(s) | | | | |
| Sister(s) | | | | |
| Son(s) | | | | |
| Daughter(s) | | | | |

**17. Any blood relative (parent, child, brother, sister, aunt, uncle) with: If "Yes", give relationship.**

| | No | Yes | Relation(s) | | No | Yes | Relation(s) |
|---|---|---|---|---|---|---|---|
| Rheumatoid Arthritis | | | | Lupus or SLE | | | |

**18. Any illnesses which run in the family?** _____

**19. Please write below all pills that you took over the last TWO WEEKS, with or without a prescription. Include aspirin, birth control pills, pain pills, alternative therapy, health supplements, pills sold in health food stores:**

| NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY | DOSE (if known) | How Many per day or week? | NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY | DOSE (if known) | How Many Per day or week? |
|---|---|---|---|---|---|
| 1. | | | 7. | | |
| 2. | | | 8. | | |
| 3. | | | 9. | | |
| 4. | | | 10. | | |
| 5. | | | 11. | | |
| 6. | | | 12. | | |

**20. What is your current occupation? (If you are not working now, what was your past occupation?)**

_____

**21. At this time, are you?**[Please check(✓)all that apply.]

__Working full time __Retired
__Working part time __Student
__Homemaker-full time __Disabled
__Seeking work __Other (describe)_____

**22. How many other people live at home with you? ___**

[Please check (✓) who lives with you.]

__Spouse/partner __Parents __Sons or daughters
__I live alone __Others (describe)_____

**23. How many years of school have you completed?**

Please circle the number of years of school:

1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

**24. Please write your weight: _____lbs. height: ___in.**

**Your Name**_____ (First Middle Last) **Today's Date**_____ **Time of Day**_____ **AM/PM**

**Street Address**_____ **City**_____ **State**_____ **Zip**_____

**Telephone (___)** _____ (Area Code Number) **Social Security #**_____ (For Identification Purposes Only) **Date of Birth** _____

**SEX:** ☐ Female ☐ Male **ETHNIC GROUP:** ☐ Asian ☐ Hispanic ☐ Other ☐ Black ☐ White **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Please check if this questionnaire is completed ☐ **entirely by patient** OR ☐ **with help from (name)**_____

**WE ASK YOU FOR CONSENT TO REVIEW YOUR RECORDS FOR MEDICAL RESEARCH AND TO CONTACT YOU IN THE FUTURE. YOUR CARE WILL NOT BE AFFECTED IF YOU ANSWER "NO."**

I agree to allow information from my medical record to be reviewed for medical research by selected colleagues of my doctor, and for you to send me similar questionnaires in the future, which I am not required to answer. I understand that this information will remain confidential with my doctor and his or her research associates only. Please check **(✓)** in **one** box. Thank you!

☐ **YES** ☐ **NO** Signature_____ Date _____

I understand and agree that my doctor may share this information with colleagues at other medical research centers, in order to learn more about best treatments for my condition. Please check **(✓)** in **one** box. Thank you!

☐ **YES** ☐ **NO** Signature_____ Date _____

**Please list the name and telephone number of your primary care physician:**

Name_____ Telephone _____

**Please list the name of your rheumatologist and insurance center:**

Rheumatologist_____ Insurance_____

**Please list the name, address, and telephone number of someone who lives at a different address from you, and who will be likely to know your whereabouts if we are unable to reach you:**

Name_____ Address_____

City, State ZIP _____ Telephone_____ Relationship _____

 **Thank you for completing this questionnaire to help keep track of your medical care. R801.51 NP4R**

**FOR OFFICE USE ONLY:** I have reviewed and recorded relevant questionnaire responses.
Date: _____ Signature_____