Adam W. Bagley, MD, FACR
Meera R. Oza, MD FACR
Diplomate of American Board of Rheumatology
Diplomate of American Board of Internal Medicine
Pinki Patel, PA Carol Hill, ARNP
2100 Kingsley Ave. Orange Park, FL 32073, Phone (904)276-0001 Fax (904) 276-5333

Dear Patient,

Welcome to Arthritis and Osteoporosis Treatment Center (AOTC). At our office we are committed to our patients. Our mission is to meet or exceed your expectations. Our providers and clinical staff will ensure quality of care, and our billing staff will give you peace of mind in making sure that all of your claims are billed correctly.

Attached are the forms required prior to your initial visit not limited to medical history forms, office policies and information related to HIPPA and your privacy rights. Please ensure these are completed prior to your visit as you cannot be seen until these forms are completed.

Please remember to call your insurance company and verify the practice participates with your insurance prior to your initial office visit. If your insurance requires a referral, please ensure this is current and active prior to each office visit. The patient will be responsible for any charges not covered by your insurance. All copays, co-insurance and deductibles will be collected at the time of visit prior to seeing the provider.

Please make sure you bring the following to your initial visit:

1. All enclosed pages completed with requested information
2. All insurance cards
3. A list of all current medications you are taking with dosages. We cannot call your pharmacy to obtain this information and we cannot prescribe medication without an accurate medication list
4. A list off all allergies
5. A copy of any blood work or imaging relevant to referral. If you prefer you may have your doctor fax results to our office at (904) 276-5333.

If you have any questions or need directions to our facility, please call us at (904) 276-0001.

Thank you and we look forward to meeting you

Adam W Bagley, MD

Meera R Oza, MD

Arthritis & Osteoporosis Treatment Center

AOTC Arthritis & Osteoporosis treatment center

PATIENT DEMOGRAPHIC FORM

Patient Information

Name (Last, First, MI) | Date

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

SSN | Date of Birth | Gender ☐Female ☐Male | Marital Status ☐ N/A (Child) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Religion (optional) | Ethnicity (optional) | e-mail address

Financially Responsible Party

Is patient responsible party/guarantor? ☐ Yes ☐ No

Name (Last, First, MI) | Relationship to patient

Street Address | City | State | Zip

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Occupation | Employer | Date of Birth

Emergency Contact

Name | Relationship to Patient

Home Phone ☐Preferred | Work Phone ☐Preferred | Cell Phone ☐Preferred

Referral Info

Referring Physician's Name | Physician Phone/Fax (if known)

Physician Address | How did you hear about us? ☐ Physician ☐ Friend ☐Website ☐Newspaper ☐Radio/TV ☐ Other _____

PCP Info

Primary Care Physician's Name ☐ Same as Referring Physician above | Physician Number

Insurance Info

Primary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

Secondary Insurance Company | Policy # | Group #

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other _____ | Name of Subscriber (if other than patient)

Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient): _____ Date: _____/_____/_____

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CONSENT FOR TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me because of treatments or examination. I have the right to refuse tests or treatment and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this. This consent continues even after a specific diagnosis has been made and treatment recommended. This consent will remain until cancelled in writing.

RELEASE OF BILLING INFORMATION FOR PAYMENT

I give my permission for Arthritis and Osteoporosis Treatment Center ("AOTC") to bill my health insurance company for services provided to the patient's name listed on this form. I agree and acknowledge that my signature on this document authorizes AOTC to submit claims for service rendered without obtaining my signature on each claim to be submitted for patient name listed on this form and that I will be bound by this signature as though the undersigned had personally signed the particular claim. During the course of treatment for the patient's name listed on this form at AOTC, I understand that there may be occasions for charges of non-face to face visits, treatment recommendations, and/or review of records. I give my permission for AOTC to bill my insurance company for these services and any amount deemed patient responsibility by the insurance company will be billed to me accordingly. I further authorize and request that insurance payments be made directly to Arthritis & Osteoporosis Treatment Center should they elect to receive such payment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To maintain continuity of care, I give permission to AOTC to release my medical records to any specialists, hospital or medical facilities associated with my care plan. I understand that Pandya Medical Center abides by HIPAA regulations and that only the records pertinent to the visit and my health will be released.

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CHANGES TO THIS NOTICE

AOTC reserves the right to change this notice. AOTC reserves the right to revise or change the notice effective for medical information on file as well as any information received in the future. AOTC will post a copy of the current notice in the practice lobby. The notice will contain on the first page in the bottom left-hand corner the effective date. In addition, each time you register for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Official at (904)276-0001. You will not be penalized for the filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to AOTC will be made only with your written permission. If you choose to provide AOTC permission to use or disclose medical information about you, you may revoke this permission in writing at any time. If you revoke your permission AOTC will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that AOTC is unable to take back any disclosures already made with your permission and that AOTC is required to retain our records of the care that we provided to you.

By signing below I acknowledge receipt of the afore outlined notices.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

Updated December 2024

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Permission To Discuss Medical Care

I hereby give permission to AOTC discuss my medical case and personal information with the following individuals:

(Please list names and relationship to you)

1. _____ Relationship to Patient _____ Phone #: _____
2. _____ Relationship to Patient _____ Phone #: _____
3. _____ Relationship to Patient _____ Phone #: _____
4. _____ Relationship to Patient _____ Phone #: _____

I understand that the above-mentioned individuals may speak to AOTC concerning my medical condition. The above also has my permission to sign for any prescriptions, imaging or medical records that may need to be picked up from the office for me in the future.

I also authorize AOTC to leave a voice messages regarding my treatment, blood work results, appointments and or billing issues.

I understand that in the future if I wish to revoke my permission, I must notify AOTC in writing.

_____
Patient signature

_____
Date

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STATEMENT OF POLICIES

The following policies are outlined for mutual convenience and benefit. Please read carefully and acknowledge understanding with signature. Questions or concerns should be addressed prior to signing.

1. We strictly provide rheumatological services. **We do not provide primary care services**. Patients are expected to have or arrange for a primary care provider. Medicare enrollees are expected to have at least one annual **well** visits with primary care provider.
2. AOTC does not perform evaluation or paperwork for disability. There will be a fee of $200 for all FMLA or accommodations forms. Turnaround time for any forms is 7 days.
3. Deductible and co-pay associated with each visit are payable at the beginning of that visit **prior** to being seen. Any outstanding balance at the beginning of the visit is also fully payable at the time of your visit. A $25 billing fee will be added to any unpaid copays, co-insurance, deductibles or balance.
4. If you are not able to pay you may make special payment arrangements with our business office at the beginning of the visit **prior** to being seen.
5. As of 1/1/2025 you may be subject to a **3% convenience fee** to all credit card transactions. This does not include debit cards, HSA, or FSA cards. Check and cash are also accepted. There will be a $50 fee for a check that returns as nonsufficient funds.
6. AOTC electronic medical record payment processing will store encrypted credit and/or debit card payment information with verbal patient consent.
7. Patient is solely responsible for all referrals required by their insurance. It is also the patient's responsibly to ensure AOTC and providers are participating with their insurance. Patient will be responsible for any charges not covered by your insurance.
8. Appointment times are when a patient should be seen by a provider. Please arrive at least 15 minutes prior to your scheduled appointment time for follow up visits. For new patient visits please arrive 30 minutes prior to appointment time if paperwork has been completed and 45 minutes prior if paperwork is being completed in the office. Patients more **than 15 minutes late** for follow up appointment times will be rescheduled. New patients who **arrive late with no paperwork completed** will be rescheduled.
9. If you are not able to keep your appointment for office visits, imaging, procedures or infusions, please call during office hours to cancel and/or reschedule your appointment at least 48 hours in advance. **Failure to do so will result in a $50.00 no show fee.** This is required to be paid prior to the next visit. Recurring no shows will be grounds for dismissal from the practice.
10. Please refrain from wearing perfumes and other scents to the office to accommodate those with allergies or intolerance.
11. During follow-up visits only, patients may be seen by a nurse practitioner or a physician assistant who work directly under the treating physician with their oversight. The physician will also see the patient when requested. This helps ensure access to timely follow-up.

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12. Foul language, racism, and or hate speech will not be tolerated. Appropriate attire is required for office visits. Office staff are to be always treated with respect. Behaviors such as these are grounds for immediate dismissal from the practice.
13. Patient will be given an Advance Beneficiary Notice of Noncoverage (ABN) for known noncovered services by insurance prior to services rendered. Patients are expected to pay associated fees in full at time of non-covered service.
14. It is the patient's responsibility to notify the office immediately of any changes to insurance policy. Patient will be solely responsible for any nonpaid claims because of incorrect insurance information.

I acknowledge that I have carefully read and understand this Statement of Policies and agree to abide by them.

Patient Name (Print)

Patient Signature

Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____

Date of Birth: _____

Phone: _____

Address: _____

I do herby I authorize the use or disclosure of the above-named individual's health information as described below. I authorize Arthritis and Osteoporosis Treatment Center to make the disclosures on my behalf

- Consultations and Progress Notes
- Imaging Data
- Laboratory Data
- Infusion and Treatment Notes

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

As required by state and federal law, Arthritis and Osteoporosis Treatment Center may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of PHI described in this form

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Arthritis and Osteoporosis Treatment center cannot guarantee that the recipient of the information will not redisclose this information contrary to such parties.

I understand that this authorization will remain in effect for one (1) year or until I revoke in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Medical Records, Arthritis & Osteoporosis Treatment Center, 2100 Kingsley Avenue, Orange Park, Florida, 32073. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release Arthritis & Osteoporosis Treatment Center and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I may be charged a fee of up to $1.00 per page for every page of printed records up to 50 pages, then 25 cents a page thereafter. This fee is waived for copies provided directly to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by Florida law.

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I hereby authorize Arthritis & Osteoporosis Treatment Center to release health information as described above. The above records are being released to:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Name: _____

Address: _____

Phone #: _____

Fax #: _____

_____

Patient Name Printed

_____

Patient signature

_____

Date

Updated December 2024

Arthritis & Osteoporosis treatment center

Patient History Form

Date of first appointment: ____/____/____ (MONTH DAY YEAR) Time of appointment: _____ Birthplace: _____

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

Address: _____ (STREET APT#) Age: _____ Sex: ❑ F ❑ M

_____ (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): _____

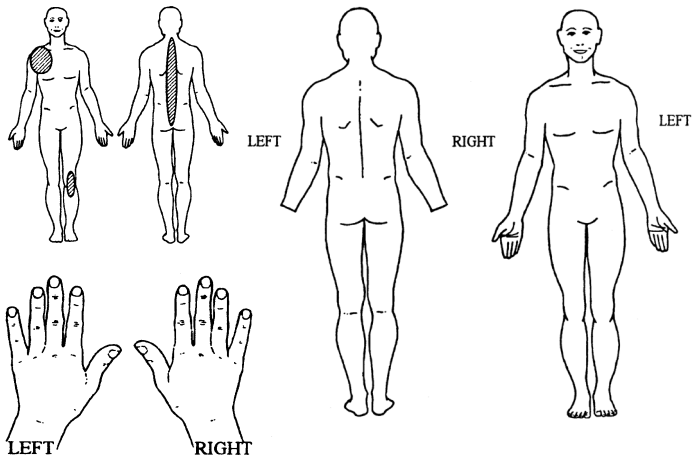
Diagnosis: _____

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
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

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.			❑	❑	❑
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	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past 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)					
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)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

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, list: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone # _____

Pharmacy Fax # _____

Mail Order/Specialty Pharmacy Name: _____

Mail Order Pharmacy Address: _____

Mail Order Pharmacy Phone # _____

Mail Order Pharmacy Fax # _____

Mail Order Pharmacy Electronic ID # _____

Patient's Name _____ Date _____ Physician Initials _____

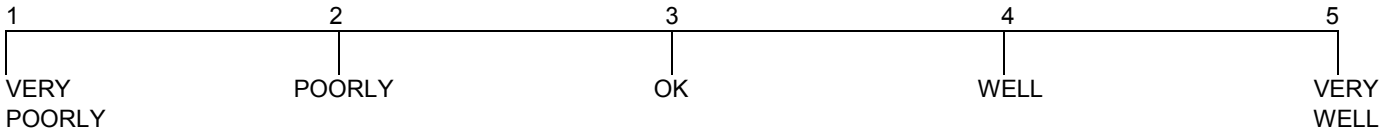
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness?	❑	❑	❑
Do you use a cane, crutches, as walker or a wheelchair? (circle one)	❑	❑	❑

What is the hardest thing for you to do?_____

Are you receiving disability? Yes ❑ No ❑

Are you applying for disability? Yes ❑ No ❑

Do you have a medically related lawsuit pending? Yes ❑ No ❑

Patient's Name _____ Date _____ Physician Initials _____