



Adam W. Bagley, 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

Arthritis & Osteoporosis Treatment Center



PATIENT DEMOGRAPHIC FORM

Patient Information	Name (Last, First, MI)						Date	
	Street Address				City		State	Zip
	Home Phone <input type="checkbox"/> Preferred		Work Phone <input type="checkbox"/> Preferred		Cell Phone <input type="checkbox"/> Preferred			
	SSN		Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> N/A (Child) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
	Religion (optional)	Ethnicity (optional)		e-mail address				
Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	Name (Last, First, MI)				Relationship to patient			
	Street Address				City		State	Zip
	Home Phone <input type="checkbox"/> Preferred		Work Phone <input type="checkbox"/> Preferred		Cell Phone <input type="checkbox"/> Preferred			
	Occupation		Employer		Date of Birth			
Emergency Contact	Name				Relationship to Patient			
	Home Phone <input type="checkbox"/> Preferred		Work Phone <input type="checkbox"/> Preferred		Cell Phone <input type="checkbox"/> Preferred			
Referral Info	Referring Physician's Name				Physician Phone/Fax (if known)			
	Physician Address		How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio/TV <input type="checkbox"/> Other _____					
PCP Info	Primary Care Physician's Name <input type="checkbox"/> Same as Referring Physician above				Physician Number			
Insurance Info	Primary Insurance Company		Policy #		Group #			
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				Name of Subscriber (if other than patient)			
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone			
	Secondary Insurance Company		Policy #		Group #			
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				Name of Subscriber (if other than patient)			
	Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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



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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 responsibility 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 hereby 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

Patient History Form

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

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

Address: _____ Age: _____ Sex: ☐ F ☐ M
STREET APT#

_____ Telephone: Home (_____) _____
CITY STATE ZIP Work (_____) _____

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
 Spouse/Significant Other: ☐ Alive/Age _____ ☐ Deceased/Age _____ Major Illnesses _____

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____
 Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

Diagnosis: _____

Previous treatment for this problem (include physical therapy,
 surgery and injections; medications to be listed later)

Please list the names of other practitioners you have seen for this
 problem:

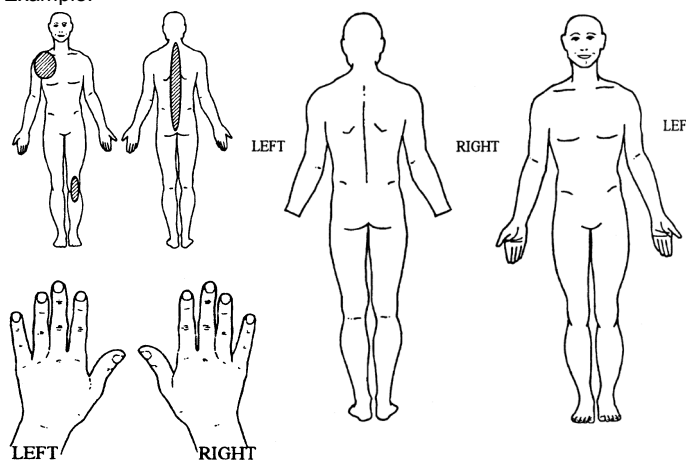
RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourselves	Relative Name/Relationship	Yourselves	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: _____			

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.

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

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)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.) _____

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	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Circle any you have taken in the past					
Ansaïd (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac)					
Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac)					
Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen)					
Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
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"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)					
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 _____
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PAST MEDICATIONS Continued

Osteoporosis Medications					
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"/>	
Gout Medications					
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"/>	
Others					
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:

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 # _____

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...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, as walker or a wheelchair? (circle one).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 ☐

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