Michigan Rheumatology
RAFIA KHALIL, M.D.

1201 Stone Street - Suite 3
Port Huron, MI 48060
Phone 810-985-5000
Fax 810-985-3700
www.MiRheum.com

NEW PATIENT FORM

Patient's Name: _____ Physician: _____

Appointment Date_____ Time: _____

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

Enclosed you will find the necessary paperwork for your upcoming appointment. Please complete the forms and bring them to the office three (3) days before your appointment. Failure to do this will result in your appointment being rescheduled.

PLEASE BRING THE FOLLOWING:

1. Medical insurance cards (i.e. Medicare, Blue Cross, etc.)
2. Photo Identification
3. Any x-rays and reports (if done within the last year)
4. Shorts for knee exams
5. List of medications

HMO INSURANCE

If you have an "**HMO**" insurance that requires an "**authorization**" from your insurance company and a "referral form" from your primary care physician*, it is your responsibility to obtain this information prior to your appointment.*

WORK INJURY OR AUTO ACCIDENTS

If your appointment is related to a "***work injury***" and/or "***auto accident***", it is your responsibility to obtain proper "***authorization in writing***" from your employer and/or insurance carrier in order to receive treatment.

We will need the following information in writing, ***ON COMPANY LETTERHEAD,*** *from your agent or employer:*

1. Date of injury
2. Insurance company name and billing address
3. Claim number

If this information is not obtained, your appointment will need to be rescheduled.

CANCELLATION POLICY

We reserve your appointment exclusively for you. We request 24 hours notice for rescheduling or cancellation of an appointment so that we may schedule another patient on our waiting list. Failure to cancel or reschedule your appointment within 24 hours of scheduled appointment will be considered a "NO SHOW" and a $25 fee will be charged. You are required to pay this fee before another appointment can be made.

One "NO SHOW" for ***new patients*** will result in a discharge of care. Two consecutive "NO SHOWS" for ***established patients*** will result in a discharge of care.

Please Initial Here _____

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PATIENT INFORMATION

Date: _____

Patient's Name: _____
(First) (M.I.) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Social Security #: ____ - ____ - _____

Birth Date: _____ / _____ / _____ ☐ Female ☐ Male
Month Day Year

Patient's Employer: _____ Phone: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Occupation: _____ Length of time employed there: _____

IF MARRIED

Spouse's Name: _____ Birth Date: _____ / _____ / _____
Month Day Year

Spouse's Social Security #: ____ - ____ - _____

Spouse's Employer: _____ Phone: _____

Spouse's Employer Address: _____
(Street) (City) (State) (Zip)

EMERGENCY CONTACT – OTHER THAN HOME PHONE

Name: _____ Relationship to patient: _____ Phone: _____

TO MEET FEDERALLY-MANDATED REQUIREMENTS, PLEASE COMPLETE THE FOLLOWING AREAS:

RACE *(select one)* ☐ American Indian/Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Decline

ETHNICITY *(select one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

LANGUAGE *(select one)* ☐ English ☐ French ☐ German ☐ Italian ☐ Spanish ☐ Japanese ☐ Mandarin ☐ Cantonese ☐ Portuguese ☐ Russian ☐ Vietnamese ☐ Hindi

CONTACT PREFERENCE ☐ Mail ☐ Phone ☐ Fax _____ ☐ Email _____

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INSURANCE INFORMATION

INSURANCE - PRIMARY

Name of Insurance Company: _____ Phone: _____

Address: _____ _____ (City) _____ (State) _____ (Zip)

Name of Insured: _____ Relationship to Patient: _____

Contract #: _____ Group #: _____

INSURANCE - SECONDARY

Name of Insurance Company: _____ Phone: _____

Address: _____ _____ (City) _____ (State) _____ (Zip)

Name of Insured: _____ Relationship to Patient: _____

Contract #: _____ Group #: _____

INSURANCE - THIRD

Name of Insurance Company: _____ Phone: _____

Address: _____ _____ (City) _____ (State) _____ (Zip)

Name of Insured: _____ Relationship to Patient: _____

Contract #: _____ Group #: _____

ASSIGNMENT AND RELEASE OF INFORMATION (FOR ALL INSURANCES, OTHER THAN MEDICARE)

I, the undersigned have insurance coverage with the mentioned company(s) on the registration form. I assign to Michigan Rheumatology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all information necessary to secure the payment of benefits. I also agree to release my information for billing purposes.

Signature of Insured: _____ **Date:** _____

MEDICARE AUTHORIZATION, ASSIGNMENT AND RELEASE OF INFORMATION

I request that payment of authorized Medicare benefits be made to either me or on my behalf, to Michigan Rheumatology for any services furnished to me by their physicians. I authorize any holder of the medical information about me to release to the HCFA, and/or its agents, any information needed to determine these benefits, or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon charge determination of the Medicare carrier.

Signature of Insured: _____ **Date:** _____

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PATIENT HISTORY

Date of first appointment: ____ / ____ / _____ Time of appointment: _____ Birthplace: _____

Name: _____ Birth date: _____ / _____ / _____
(Last) (First) (M.I.) (Maiden)

Address: _____ Age: _____ Sex: ☐ Female ☐ Male
(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 completed)
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: ("X" one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional
Name of person who made 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*)

_____

_____

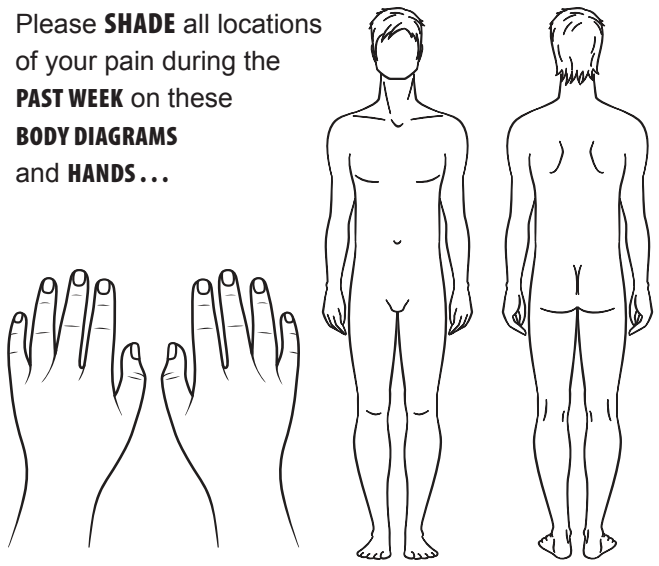
_____

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

_____

_____

Please **SHADE** all locations of your pain during the **PAST WEEK** on these **BODY DIAGRAMS** and **HANDS . . .**



RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have YOU or a BLOOD RELATIVE had any of the following? ("X" 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'S INITIALS** _____

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SYSTEMS REVIEW

As you review the following list, please "X" any problems which have significantly affected you.

Date of last eye exam _____ / _____ / _____

Date of last tuberculosis test _____ / _____ / _____

Date of last chest x-ray _____ / _____ / _____

Date of last bone densitometry _____ / _____ / _____

Date of last mammogram _____ / _____ / _____

CONSTITUTIONAL

- ☐ Recent weight gain amount _____ lbs
- ☐ Recent weight loss amount _____ lbs
- ☐ 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 MONTHS:

_____ _____

_____ _____

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'S INITIALS** _____

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HISTORY REVIEW

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No

If Yes, how many cups/glasses per day? _____

Do you smoke? ☐ Yes ☐ No ☐ Past - How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Have you ever been told 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 have, or ever had: **("X" 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.		

Any previous fractures? ☐ Yes ☐ No Describe: _____

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

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Current 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: ("X" 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'S INITIALS** _____

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MEDICATIONS

Drug Allergies? ☐ No ☐ Yes – To What? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS

Please list any medications you are currently taking. Include such items as: aspirin, vitamins, laxatives, calcium & other supplements, etc.

NAME OF DRUG	DOSE - INCLUDE STRENGTH & NUMBER OF PILLS PER DAY	HOW LONG HAVE YOU TAKEN THIS MEDICATION?	PLEASE "X" – MEDICATION HELPED.... A LOT	SOME	NOT AT ALL
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐

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.

DRUGS NAMES / DOSAGE	LENGTH OF TIME TAKEN	PLEASE "X" – MEDICATION HELPED.... A LOT	SOME	NOT AT ALL	ANY REACTIONS?
PAIN RELIEVERS					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Tramadol (Ultram)		☐	☐	☐	
Other:		☐	☐	☐	
DISEASE MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Leflunomide (Arava)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Adalimumab (Humira)		☐	☐	☐	
Abatacept (Orencia)		☐	☐	☐	
Certolizumab Pegol (Cimzia)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

PATIENT'S NAME _____ **DATE** _____ **PHYSICIAN'S INITIALS** _____

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MEDICATIONS CONTINUED...

DRUGS NAMES / DOSAGE	LENGTH OF TIME TAKEN	PLEASE "X" – MEDICATION HELPED.... A LOT	SOME	NOT AT ALL	ANY REACTIONS?
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)		☐	☐	☐	

PLEASE CIRCLE ANY MEDICATIONS THAT 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)

OSTEOPOROSIS MEDICATIONS	LENGTH OF TIME TAKEN	HELPED A LOT...	SOME	NOT AT ALL	ANY REACTIONS?
Estrogen (Premarin)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Ibandronate (Boniva)		☐	☐	☐	
Calcitonin injection/nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Denosumab (Prolia)		☐	☐	☐	
Zoledronic Acid (Reclast)		☐	☐	☐	
Vitamin D Rx		☐	☐	☐	
Other:		☐	☐	☐	
GOUT MEDICATIONS	**LENGTH OF TIME TAKEN**	**HELPED A LOT...**	**SOME**	**NOT AT ALL**	**ANY REACTIONS?**
Probenecid (Benemid)		☐	☐	☐	
Colchicine (Colcrys)		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Febuxostat (Uloric)		☐	☐	☐	
Other:		☐	☐	☐	
OTHER MEDICATIONS	**LENGTH OF TIME TAKEN**	**HELPED A LOT...**	**SOME**	**NOT AT ALL**	**ANY REACTIONS?**
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiludronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc injections		☐	☐	☐	
Herbal or Nutritional Supplements					
Please list any other Supplements:					

HAVE YOU PARTICIPATED IN ANY CLINICAL TRIALS FOR NEW MEDICATIONS?

☐ No ☐ Yes – Please List: _____

_____

_____

_____

_____

PATIENT'S NAME _____ **DATE** _____ **PHYSICIAN'S INITIALS** _____

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ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ No ☐ 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 the number which best describes your situation – ***MOST OF THE TIME, I FUNCTION...***

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

PLEASE "X" THE APPROPRIATE RESPONSE FOR EACH QUESTION

Because of health problems, do you have difficulty:

	Usually	Sometimes	Never
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: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair	☐	☐	☐
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'S INITIALS** _____