Mary Washington
Rheumatology

Dear Patient:

Welcome to Mary Washington Rheumatology. We are pleased to have the opportunity to participate in your care. For your convenience, and to help make your first visit go smoothly, **please arrive 30 minutes prior to your scheduled appointment and bring the following items with you:**

- Completed Patient Intake Packet (enclosed)
- Patient Medical History Form (enclosed)
- Current Insurance Card(s)
- Photo I.D.
- InsuranceReferral
- Insurance Co-pay to be collected at your visit

Our office is located on the 3rd floor of 1300 Hospital Drive on the Mary Washington Hospital campus. Please note, failure to arrive 30 minutes prior to your appointment may result in rescheduling your new patient appointment. You may drop off the enclosed forms at any time prior to your appointment. If you have any questions or concerns, please contact our office directly at the number listed below.

Thank you for choosing Mary Washington Rheumatology. We look forward to meeting you soon.

Sincerely,
Mary Washington Rheumatology
1300 Hospital Drive, Suite 301
Fredericksburg, VA 22401

Mary Washington Rheumatology

1300 Hospital Drive, Suite 301
Fredericksburg, VA 22401
P: 540.899.3595 | **F**: 540.899.3599
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Patient History Form

Date of first appointment: _____/_____ / _____ Time of appointment: _____Birthplace:

Name:_____ Date of Birth: _____ / _____ / _____
Last First Middle Inital Madden Month Day Year

Address:_____ Age:_____ Sex: ❑ F ❑ M
Street APT#

_____ Phone: (home) _____
City State Zip (work) _____

Marital Status: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illinesses:_____

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: _____

Describe briefly your present symptoms:_____
_____
_____
_____

Date symptoms began *(approximate)*: _____

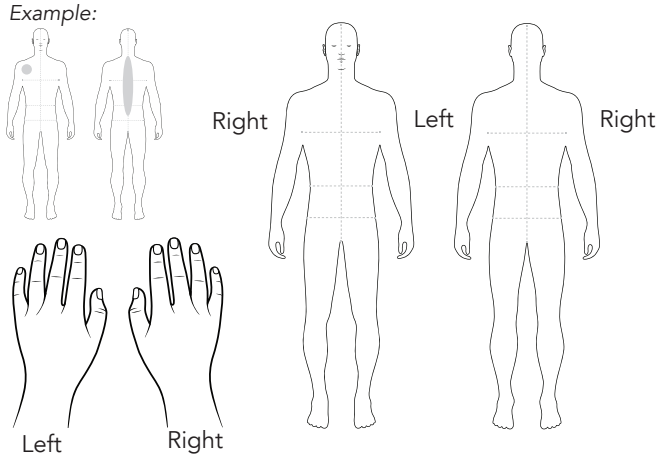
Diagnosis: _____

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

_____
_____
_____

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

Example:



Rheumatologic (Arthritis) History

At anytime 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 Name:_____ Date:_____ Physician initials:_____

SYSTEMS REVIEW

As you review the following list, please check any 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 throat
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomitting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stool
- ❑ Black stool
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/urination
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when period began: _____

Period 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 miscarriage? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling
  List joints affected in the last 6 mons.
  _____
  _____
  _____
  _____
  _____

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

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

Other significant illness *(please list)* _____
_____

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

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ Yes ❑ No Describe: _____
Any other serious injuries? ❑ Yes ❑ No Describe: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings_____ Number living _____ Number decreased_____
Number of Children_____ Number living Number decreased _____ List ages of each,_____
Health of children_____

Do you know 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 Name: _____ Date: _____ Physician initials:_____

MEDICATIONS:

Drug allergies: ❑ Yes ❑ No If yes, please list: _____

_____

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/Dose	Lenght of time	Please check: Helped? A lot	Some	Not at all	Reactions
Non-steroidal anti-inflammatory drugs (NSAIDs)		❑	❑	❑	

Please check any you have taken in the past.

- ❑ Flurbiprofen
- ❑ Oxaprozin
- ❑ Iburofen
- ❑ Diciofenac + misoprostil
- ❑ Salsalate
- ❑ Fenoprofen
- ❑ Diflunisal
- ❑ Naproxen
- ❑ Aspirin (including coated aspirin)
- ❑ Piroxicam
- ❑ Ketoprofen
- ❑ Indomethacin
- ❑ Tolmetin
- ❑ Celecoxib
- ❑ Etodolac
- ❑ Choline magnesium trisaicylate
- ❑ Sulindac
- ❑ Meciofenamate
- ❑ Diclofenac

Drug names/Dose	Lenght of time	Please check: Helped? A lot	Some	Not at all	Reactions
Pain Relievers		❑	❑	❑	
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient Name: _____ Date: _____ Physician initials: _____

PAST MEDICATIONS: *Continued*

Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychioroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Alloprinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

Please list supplements:

_____

_____

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

If yes, list: _____

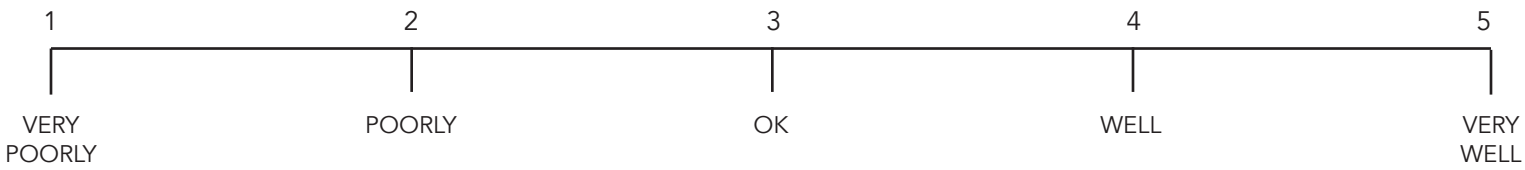
_____

_____

Patient 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?	❑	❑	❑
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, walker or 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 Name: _____ Date: _____ Physician initials: _____