RHEUMATOLOGY ASSOCIATES, P.C.

NEW APPOINTMENT CHECKLIST

____Completed Medical History Packet

____All Medications Including Over the Counter and Supplements Including Vitamins and Calcium. These should be in their original containers.

____Picture Identification

____Insurance Cards

____If you are not the primary person on the insurance card need to have the primary insured's full name, social security number, birth date and address.

____Co-Pay (Cash, Check, Discover, Mastercard, Visa)

RHEUMATOLOGY ASSOCIATES, PC

David B. Staub, M.D., Sunita Penmatcha, M.D., Susan G. Freburg, A.R.N.P.
3740 Utica Ridge Road • Bettendorf, Iowa 52722
(563) 359-4440 • (563) 359-4644 fax

Please answer all questions as completely and accurately as possible, your medical history is very important to your care.

Name: _____ Birthdate_____
Last First Initial

Preferred Language _____Race_____E-mail Address_____

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____Unknown

Emergency Contact Name/Relationship/Phone Number_____

_____

Primary Care Provider_____Eye Care Provider_____

Drug Allergies ___Yes ___ No If yes, to what and what is the reaction _____

_____

Date of Last Eye Exam_____ Date of Last Tuberculosis Test_____

Date of Last Chest X-Ray_____Date of Last Bone Density Test_____

Briefly Describe Your Present Symptoms_____

_____

_____

_____

Date Symptoms Began_____

Previous Treatment For this Problem: (Include physical therapy, surgery and injections)

_____

_____

_____

Names of Other Practitioners Seen for this Problem:

Past Medical History: Do you now or have you ever had (circle and indicate date and type if yes)

Anemia	Heart	Nervous Breakdown
Asthma	Hepatitis	Pneumonia
Cancer	High Blood Pressure	Psoriasis
Cataracts	HIV/AIDS	Rheumatic Fever
Diabetes	Inflammatory Bowel Disease	Sleep Apnea
Emphysema	Jaundice	Stomach Ulcers
Epilepsy	Kidney Disease	Stroke
Glaucoma	Leukemia	Thyroid Disorder
Goiter	Migraines	Tuberculosis

Other significant Illness

Previous Operations (Year and Type):

1.

2.

3.

4.

5.

6.

7.

Any Previous Fractures (Left/Right and Month/Year):

_____

_____

Any Other Serious Injuries_____

_____

Social History:

Employer_____Occupation_____

Number of Hours Worked Per Week_____

Do you use alcohol? ___Yes ___No If Yes, frequency and type_____

Do you use tobacco? ___Current ___Former ___Never Type_____ Quantity_____

Have you ever tried to quit? ____Yes ___No If quit what year _____

Highest Level of Education Completed_____

Tattoos ___Yes ___No

IV Drugs_____Never___ ___Past_____Current

Marital Status:

_____Single _____Married _____Divorced _____Separated _____Widowed ____Life Partner

Pregnant _____ Contraception_____ Menopause Age _____

Signature_____Date_____

Please complete the family health history on the next page.

Family Health History

Relation	First Name	Age if Living	Age at Death	Cause of Death
Mother				
Father				
Full Brothers:				
Full Sisters:				
Natural Children:				

Have any of the following diseases been diagnosed in your family? Please list only if relative is your natural (blood-related) father, mother, full brothers, full sisters, or natural children. Please list how this person is related and their first name.

Please list even if the relative is not living.

- Rheumatoid Arthritis:

  _____

  _____

- Lupus:

  _____

  _____

- Gout:

  _____

  _____

- Ankylosing Spondylitis:

  _____

- Sjogren's:

  _____

- Osteoporosis/ Hip Fracture/ Spinal Fracture:

  _____

- Psoriasis/ Crohn's Disease/ Ulcerative Colitis:

  _____

- Other Rheumatic Diseases (such as vasculitis, polymyalgia rheumatic, psoriatic arthritis):

  _____

- Fibromyalgia:

  _____

- Cancer (please specify which type if known):

  _____

- Heart Disease:

  _____

- Alcoholism:

  _____