RHEUMATOLOGY ASSOCIATES, P.C.

NEW APPOINTMENT CHECKLIST

C	Completed medical history packet.
A	Il medications in original containers, including both prescription and over the counter nedications and supplements.
Pio	cture identification.
In	surance cards.
If in	you are not the primary person on the insurance card we will need to have the primary sured's full name, social security number, and date of birth.
Co	o-Pay (cash, check, Discover, MasterCard, and Visa are accepted)
If you	will need directions to our clinic, please feel free to contact us at 563-359-4440

RHEUMATOLOGY ASSOCIATES, PC

David B. Staub, M.D., Sunita K. Penmatcha, M.D., Lindsay J. Orris, D.O., Mudappa K. Kalaiah, M.D.
2979 Victoria Street • 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	<u> </u>
Last	First	Initial	У.
Preferred Language	Race	E-mail Address	
Ethnicity:Hispanic	or LatinoNot H	ispanic or LatinoUn	known
Emergency Contact Name/Rel	ationship/Phone Num	ber	a a
y y		2	
Primary Care Provider			
Drug AllergiesYes No	o If yes, to what and	what is the reaction	
Date of Last Eye Exam		Date of Last Tuberculosis Te	st
Date of Last Chest X-Ray	Da	te of Last Bone Density Test_	
Briefly Describe Your Present S	ymptoms	Ω N	
			10-2011/0
Date Symptoms Began			
Previous Treatment For this Pro	blem: (Include physic	cal therapy, surgery and injec	ctions)
	# 5 S		
X			

ners Seen for this Problem:	
you now or have you ever had (circle a	nd indicate date and type if yes)
Heart	Nervous Breakdown
Hepatitis	Pneumonia
High Blood Pressure	Psoriasis
HIV/AIDS	Rheumatic Fever
Inflammatory Bowel Disease	Sleep Apnea
Jaundice	Stomach Ulcers
Kidney Disease	Stroke
Leukemia	Thyroid Disorder
Migraines	Tuberculosis
and Type):	
	27 E

7.____

Any Previous Fractures (Left/Right and Month/Year):
Any Other Serious Injuries
Social History:
EmployerOccupation
Number of Hours Worked Per Week
Do you use alcohol?YesNo If Yes, frequency and type
Do you use tobacco?CurrentFormerNever TypeQuantity
Have you ever tried to quit?YesNo
Highest Level of Education Completed
TattoosYesNo
IV DrugsNeverPastCurrent
Marital Status:SingleMarriedDivorcedSeparatedWidowedLife Partner
regnant Contraception Menopause Age
referred Pharmacy
gnatureDate

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			Death	
Father				
Full Brothers:				
		-		
		4		
				. ^
	_			
			.172	
				-
ull Sisters:				_
			241	
	± ₹	F		
		10		2 2
			-	
			-	
				·
atural Children:				
atural Chharen.				
			MA.	S42 6
			1901	Tr.
		l .		
				Al di

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:
C	Gout:
0	Ankylosing Spondylitis:
0	Sjogren's:
0	Osteoporosis/ Hip Fracture/ Spinal Fracture:
0	Psoriasis/ Crohn's Disease/ Ulcerative Colitis:
0	Other Rheumatic Diseases (such as vasculitis, polymyalgia rheumatic, psoriatic arthritis):
0	Fibromyalgia:
0	Cancer (please specify which type if known):
0	Heart Disease:
0	Alcoholism: