RHEUMATOLOGY ASSOCIATES, P.C.

New Appointment Checklist

Please bring the following to your appointment.

- ☐ Completed medical history packet.
- ☐ All medications in original containers, including both prescription and over the counter medications and supplements.
- ☐ Picture identification.
- ☐ Insurance cards.
- ☐ If you are not the primary person on the insurance card we will need to have the primary insured's full name, social security number, and date of birth.
- ☐ Co-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.

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Patient Information & Symptoms

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.

Last name | **First name** | **Initial** | **Birthdate**

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)

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Past Medical History

Patient name | Date

Names of other practitioners seen for this problem

PAST MEDICAL HISTORY

Do you now or have you ever had any of the following? Select all that apply and indicate date and type if yes.

Condition Date and type, if yes	Condition Date and type, if yes	Condition 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.

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Injuries & Social History

Patient name | Date

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

Preferred pharmacy

Signature | Date

Please complete the family health history on the next page.

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Family Health History

Patient name | Date

Relation	First name	Age if living	Age at death	Cause of death
Mother				
Father				
Full Brothers:				
Full Sisters:				
Natural Children:				

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Family Medical Conditions

Patient name | Date

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