ARTHRITIS & RHEUMATOLOGY CLINIC

The Arthritis and Rheumatology Clinic
740 Jordan Street Shreveport, Louisiana 71101
(318) 424-9240 Fax (318) 424-0022
Website: www.louisianaarthritisclinic.com • www.arthdoc.com

Welcome to our practice!

Welcome to our practice! It is our honor to partner with you in your healthcare. The information on this cover sheet answers common questions our new patients have. We hope you will find this information helpful and reassuring. Should you have any further questions, please do not hesitate to call us. We look forward to seeing you in the office soon!

It is very important that you fill out the enclosed forms before your visit. Allow yourself 30 minutes to an hour to fill them out. Upon completion, you may either mail them to us prior to your appointment; or bring them with you when you come.

Plan to arrive 15 minutes before your appointment time. Doing so will allow the front office staff to process your information, and get you in to see the doctor on time.

Your first appointment will last for about 1-1/2 to 3 hours. Subsequent "follow-up" visits usually last around 30 minutes to one hour. A recorded message will be sent confirming your follow-up visits 2 business days prior to your appointment.

Bring your insurance card(s) and driver's license with you for every visit. We will scan them before each appointment.

It is important to note that any co-pay amounts, or percentage totals that your insurance company requires, are processed when you check in. We accept cash, VISA, MasterCard, and Discover.

Please bring all medications that you are currently taking. This includes vitamins and herbal supplements.

Should you need to cancel your appointment for any reason, we ask that you kindly give us 24 hours' notice of cancellation, so that the time set aside for you can be offered to someone else who needs to get in to see the doctor.

Thank you for your cooperation. We hope your visit is a pleasant one. And again, if you have any questions, feel free to contact our office at 318-424-9240.

Sincerely,

Your Health Care Team at the Arthritis and Rheumatology Clinic

Arthritis and Rheumatology Clinic (ARC)

Acknowledgment Form for Receipt of ARC HIPAA Notice of Privacy Practices*

As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all that we can to secure and protect that privacy. We support your right to full access to your personal medical records.

We have provided you with a detailed copy of our HIPAA Notice of Privacy Practices which comprises pages 3 – 7 of this patient packet. A copy of the ARC HIPAA Notice of Privacy Practices is also available on our website: www.louisianaarthritisclinic.com, or www.arthdoc.com.

We assure you that we strive to achieve the very highest standards of ethics and integrity in performing services for our patients. We have a HIPAA Compliance Program in place which provides guidelines, policies and procedures regarding appropriate use of our patients' PHI (Protected Health Information). All of our employees, managers, and providers continually undergo training in order to fully understand and comply with government rules and regulations regarding HIPAA with particular emphasis on the Privacy Rule.

If you have any concerns or objections, you may call our office at 318-424-9240; and ask to speak with our HIPPA Compliance Officer. There is also contact information for the Regional Office of the Department of Health and Human Services on the last page of our Notice of Privacy Practices (page 7 in your patient packet.)

Please sign & date this form to confirm that you have received your copy of our Notice of Privacy Practices. Thank you for being one of our highly valued patients.

I acknowledge that I have received a copy of the ARC Notice of Privacy Practices.

Signature:____________________________________ **Date:** _____/_____/______

Print Name:____________________________________

*HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by the United States Congress in 1996. The United States Government Department of Health and Human Services states that the HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

ARTHRITIS & RHEUMATOLOGY CLINIC

ROBERT E. GOODMAN, M.D.
Board Certified Rheumatology
Board Certified Internal Medicine

740 Jordan Street
Shreveport, Louisiana, 71101
phone 318 424-9240
fax 318 424-0022

NOTICE OF PRIVACY PRACTICES

Robert E. Goodman, M.D. The Arthritis & Rheumatology Clinic

Johnnie Lindberg, Office Manager & Clinic Privacy Officer, (318)-424-9240

Effective Date: September 16, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer in the form of an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or

otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

23. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

24. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

25. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

26. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

27. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

28. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website: www.louisianaarthritisclinic.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)
Jorge Lozano, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
Voice Phone (800) 368-1019
FAX (214) 767-0432
TDD (800) 537-7697

OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

ARTHRITIS & RHEUMATOLOGY CLINIC

ROBERT E. GOODMAN, M.D.
Board Certified Rheumatology
Board Certified Internal Medicine

740 Jordan Street
Shreveport, Louisiana 71101
Phone 318-424-9240
Fax 318-424-0022

Date ______________________

I ______________________________ give my permission to Dr. Robert E. Goodman and/or his staff to discuss my medical treatment with the following:

____ relationship

____ relationship

____ relationship

Patient signature ____

Witness ____

ARTHRITIS & RHEUMATOLOGY CLINIC

Date ____________________

Account: ____________________

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PATIENT INFORMATION

Patient Name	Social Security	Age	Date of Birth	Sex ☐ M ☐ F
Address	City		State	Zip Code

☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	Spouse's Name	Phone	Cell Number	E-mail
Please tell us who referred you to us:			Drug Allergies	

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses – If same as above check ☐ Self	Name	Phone Number

Addressee	City	State	Zip Code

I understand this clinic will not treat the aspects of my care that are part of a workers compensation claim. X ____________________

EMPLOYMENT INFORMATION

Employed ☐ Yes ☐ No	Employer (Father's if minor)

Address	City	State	Zip Code

Position	Business Phone Number
Spouse's Employer (or Mother's)	Address
Position	Business Phone Number

INSURANCE INFORMATION (Please list all)

Medicare Number	Medicaid No.	State

Insurance Co. Name & Address	Name of Policy Holder	DOB	Social Security
Insurance Co. Name & Address	Name of Policy Holder	DOB	Social Security

EMERGENCY INFORMATION

Person to contact in case of emergency other than person living in house with patient:	Relationship

Address	City	State	Phone Number	Cell Number

CONSENT FOR TREATMENT – RELEASE OF INFORMATION

I consent to treatment necessary for the care of the patient mentioned above. I hereby authorize the release of all medical records to referring physicians and to my insurance companies with the following exceptions.

X ____________________
Signature of patient or guardian

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED ATTACHED.

X ____________________
Signature

Thank You for taking time to complete this form. This information is necessary for the preparation of your clinic records. You are responsible for all charges as billed. Any service charges for past due or collection accounts will be the responsibility of the patient. As a courtesy, we will file your insurance or Medicare. However, your contract is with your insurance company. They are responsible to make payments directly to you. You are responsible for full payment as billed. If extended terms are desired on large balances, our credit office personnel will be happy to discuss a payment schedule most convenient for you.

ARTHRITIS & RHEUMATOLOGY CLINIC

ROBERT E. GOODMAN, M.D.
Board Certified Rheumatology
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Phone 318-424-9240
Fax 318-424-0022

I authorize the Arthritis and Rheumatology Clinic to download my personal medication history and pharmacy benefits.

______________________________________ __________________________

Signature date

The Arthritis and Rheumatology Clinic
740 Jordan Street Shreveport, Louisiana 71101
(318) 424-9240 Fax (318) 424-0022

ROBERT E. GOODMAN, M.D.

A Professional Medical Corporation

MEDICAL INFORMATION

Name ______________________ Date ____________ Medicare Number ______________

OTHER INSURANCE:

Do you receive medical benefits from the Veteran's Administration?
NO YES Explain ______________________________

Do you receive medical benefits from the Black Lung Program?
NO YES Explain ______________________________

Do you receive medical benefits from a Medicare Program?
NO YES STATE ____________ CARD NUMBER ______________________
Please show CURRENT card when returning this form.

Are you currently receiving medical benefits from a liability claim?
NO YES Explain ______________________________

Are you currently receiving medical benefits from a workman's comp claim?
NO YES Explain ______________________________

Are you employed? NO YES WHERE ______________________________

If yes, do you have insurance with this company?
NO YES INSURANCE ______________________ NUMBER ____________
Please show insurance card when returning this form.

Is your spouse employed? NO YES WHERE ______________________________

Does your spouse have insurance coverage for you with this company?
NO YES INSURANCE ______________________ NUMBER ____________
Please show insurance card when returning this form.

Do you have medical insurance other than Medicare and other than those listed above?
NO YES INSURANCE ______________________ NUMBER ____________
Please show insurance card when returning this form.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Arthritis and Rheumatology Clinic, APMC for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature ______________________ Date ____________

PATIENT HPI QUESTIONAIRE

ARTHRITIS AND RHEUMATOLOGY CLINIC

Date of First Appointment ______/______/_______ Birthplace: ______________________________
Month Day Year

Name: ____ Birthdate: _____/_____/________
Last First Middle Initial Maiden Month Day Year

Address: ____ Age: _____ Sex: F M
Street Apt. #

____ Telephone: Home ( ) ___________
City State Zip

Referred here by: (check one) Self Family Friend Doctor Other Health Professional

Name of person making referral ____

The name of the physician providing your general medical care? ______________________________

Do you have an orthopedic surgeon? Yes No If yes, Name ______________________________

Describe briefly your present symptoms: ____

____

____

____

Date symptoms began (approximate) ______________________ Diagnoses given? (Please list)

____

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

____

____

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

____

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, toothbrushes, pencils, 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 other family members?	______	______	____
In your sexual relationships?	______	______	____
Engaging in leisure time activities?	______	______	____
With morning stiffness?	______	______	____
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)	______	______	____

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 ___

MEDICATIONS:

PATIENT HPI QUESTIONAIRE

List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

Name of Drug	Dose (Include Strength and Number of Pills per Day)	How long have you taken this medications?	Please Check: Helped? A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

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/Dosages	Length of Time	Results A Lot	Some	Not at All	Reactions
1. Asprin/Zorprin					
2. Asprin—containing product					
3. Easprin containing Ascripten					
4. Disalcid/Salsalate/Trilisate					
5. Tylenol (plain) /with codeine					
6. Darvon/Darvocet					
7. Ansaid					
8. Clinoril					
9. Daypro					
10. Feldene					
11. Indocin					
12.Lodine					
13. Meclomen					
14. Motrin/Rufen/Ibuprofen					
15. Nalfon					
16. Naprosyn					
17. Orudis/Orudis					
18. Relafen					
19. Tolectin					
20. Voltaren/Cataflam					
21.Cortisone/Prednisone/Medrol					
22.Benemid/CoBenemid					
23. Colchicine					
24. Zyloprim/Lopurin/Allopurinol					
25. Gold (shots or pills)					
26. Plaquenil					
27. Penicillamine					
28. Methotrexate/Rheumatrex					
29. Imuran					
30. Cytoxan					
31. Azulifidine					

Reviewed by: ___________ Date: ________________

PATIENT HPI QUESTIONAIRE

SYSTEMS REVIEW

As you review the following list, **please check any of those problems which apply to you.**

GENERAL:
____ Recent weight gain/Amount
____ Recent loss of weight/Amount
____ Fatigue/Tiredness
____ Weakness
____ Fever

NERVOUS SYSTEM:
____ Headaches
____ Dizziness
____ Fainting
____ Muscle spasm
____ Loss of consciousness
____ Numbness or tingling of hands and/or feet
____ Memory loss

EAR:
____ Ringing in ears
____ Loss of hearing

EYES:
____ Pain
____ Redness
____ Loss of vision
____ Double or blurred vision
____ Dryness
____ Feels like something in eye

NOSE:
____ Nosebleeds
____ Loss of smell
____ Sores in nose
____ Dryness

MOUTH:
____ Sore tongue
____ Bleeding gums
____ Sores in mouth
____ Loss of taste
____ Dryness

THROAT:
____ Frequent sore throats
____ Hoarseness
____ Difficulty in swallowing

Date of last eye examination _______
Date of last chest X-Ray __________
Date of last Tuberculosis Test ______

NECK:
____ Swollen glands
____ Tender Glands

HEART AND LUNGS:
____ Pain in chest
____ Irregular heart beat
____ Sudden changes in heart beat
____ Shortness of breath
____ Difficulty in breathing at night
____ Swollen legs or feet
____ High blood pressure
____ Heart murmurs
____ Cough
____ Coughing blood
____ Wheezing
____ Night sweats

STOMACH AND INTESTINES:
____ Nausea
____ Vomiting of blood or coffee ground material
____ Stomach pain relieved by food or milk
____ Yellow Jaundice
____ Increasing constipation
____ Persistent diarrhea
____ Blood in stools
____ Black stools
____ Heartburn

KIDNEY/URINE/BLADDER:
____ Difficult urination
____ Pain or burning on urination
____ Blood in urine
____ Cloudy, "smoky" urine
____ Pus in urine
____ Abnormal discharge from penis/vagina
____ Frequent urination
____ Getting up at night to pass urine
____ Vaginal dryness
____ Rash/ulcers
____ Sexual difficulties
____ Prostate trouble

BLOOD:
____ Anemia
____ Bleeding tendency

SKIN:
____ Easy bruising
____ Redness
____ Rash
____ Hives
____ Sun sensitive (sun allergy)
____ Tightness
____ Nodules/bumps
____Hair loss more than normal
____ Color changes of hands or feet in the cold
____Psoriasis

MUSCLES/JOINTS/BONES:
____ Morning stiffness
Lasting how long
____ Minutes
____ Hours
____ Joint pain
____ Muscle weakness
____ Muscle tenderness
____ Joint swelling

SLEEP:
How is your sleep? Good Fair Poor
Do you get enough sleep? Yes No
How many hours? ________________
Trouble getting to sleep? Yes No
Do you awaken during the night?
Yes No _______ # of Times
Why? ____________________________
Do you awaken too early? Yes No
Do you wake up feeling tired? Yes No

HABITS:
Do you drink coffee? __________________
Caf Decaf
Cups per day? ______________________
Do you smoke? Yes No Past
Cigarettes per day? __________________
Do you drink alcohol? Yes No
If so, how much per day or week? _________
____
Do you use drugs for reasons that are not medical? If so, please list ____________
____
____
____

FOR WOMEN ONLY:
Age when period began: _________ Periods regular: Yes No How many days apart: ______ Date of last period: ______________
Date of last Pap smear: __________ Date of last breast exam: ___________________ Date of last mammogram: ________________
Planning pregnancy? Yes No

PATIENT HPI QUESTIONAIRE

DRUG ALLERGIES AND SIDE EFFECTS: YES NO

Name of Drug	Describe Reaction or Side Effect
1.	
2.	
3.	
4.	
5.	
6.	

SOCIAL HISTORY:

Never Married Married Divorced Separated Widowed

Spouse: Alive/Age _______ Deceased/Age ______ Major Illnesses: ________________

Number of people in household _____(including you) Children ______________ Age of youngest _____

Occupation (yours):

____

EDUCATION: (*circle highest level attended*)

Grade School Junior High School 7 8 9 College 1 2 3 4

High School 10 11 12 Graduate School

PAST PERSONAL HISTORY:

Do you or have you had: (check if 'yes')

Cancer _______________ Heart Problems _____ Asthma ___________ Inflamatory Bowel Disease _____

Cataracts _____________ Diabetes __________ Stomach ulcers ____ Nervous breakdown __________

Anxiety/Nervousness ___ Rheumatic Fever ___ Bad Headaches ___ Irritable colon ________________

Kidney Disease ________ Pneumonia ________ Psoriasis _________ Anemia ____________________

High Blood Pressure ____ Diverticulitis _______ Nervous stomach __ Hayfever ___________________

Other significant illness (please list): ____

Pregnancies (how many) __________ Problems: ____

PREVIOUS OPERATIONS:

Including cataracts, plastic surgery, etc.

	Type	Year	Surgeon	City
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Any previous fractures? No Yes Describe (location & year) ______________________________

Any other serious injuries? No Yes Describe (location & year) ____________________________

Received By: ___________

Date: _________________

FAMILY RHEUMATOLOGIC (ARTHRITIS) HISTORY:

At any time have you or a blood relative had any of the following? (Check if "yes")

blood relative who has the arthritic condition; name/relationship

Arthritis (type unknown) ____________________

Osteoarthritis ____________________

Rheumatoid Arthritis ____________________

Gout ____________________

Lupus of "SLE" ____________________

Ankylosing spondylitis ____________________

Childhood arthritis ____________________

Osteoporosis ____________________

Psoriasis ____________________

Ulcerative Colitis ____________________

Crohns Disease ____________________

Uveitis or Iritis ____________________

Hemophilia or Blood Disorders ____________________

Diabetes ____________________

OTHER CONDITIONS: ____________________

NOTES: ____________________

Other Doctors you are currently seeing:

Would you like a copy of your evaluation sent to a physician? (check box to send copy)

Name: ____________________
Address: ____________________

Name: ____________________
Address: ____________________

Name: ____________________
Address: ____________________

Name: ____________________
Address: ____________________

Name: ____________________
Address: ____________________

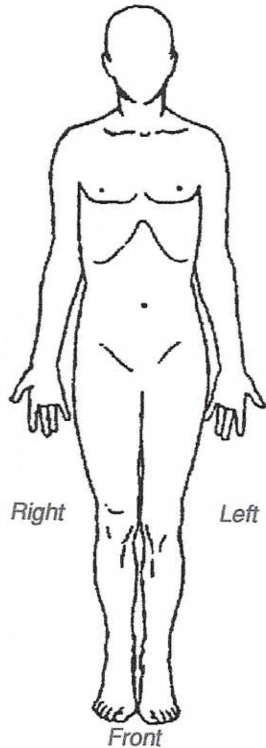
Reviewed By: ________
Date: ________

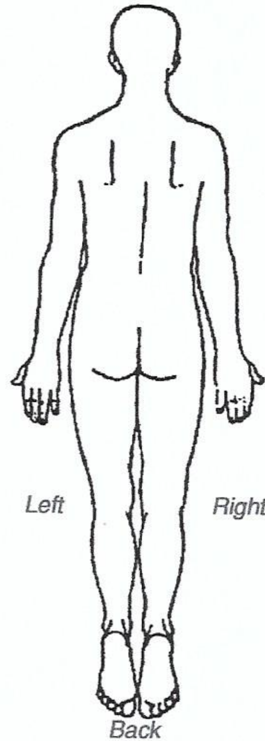
Where is your pain now?

PATIENT HPI QUESTIONAIRE

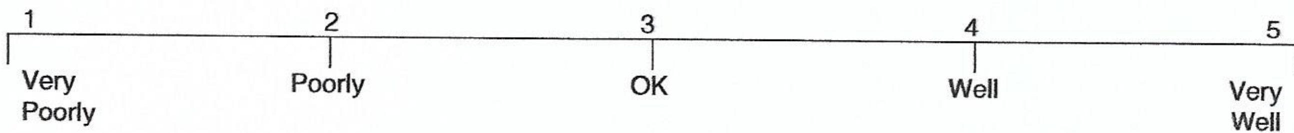
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. Circle the areas that swell. To complete the picture, please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
• • •	= = =		X X X	/ / /

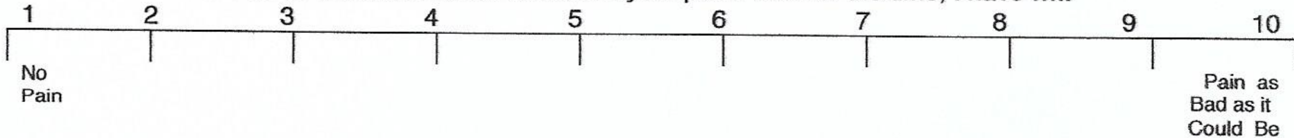




On the scale below, circle a number which best describes your situation: Most of the time, I function .....



On the scale below circle a number which describes your pain: Most of the time, I have .....



The Arthritis and Rheumatology Clinic
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ROBERT E. GOODMAN, M.D.

A Professional Medical Corporation

We're easy to find!

No matter where you live in the Ark-La-Tex, the Arthritis & Rheumatology Clinic is easy to find, and ready to assist you.