LANSING RHEUMATOLOGY

EAST LANSING, MI

Patient History Form

Name: ____ Birthdate: _______________
Last First MI Maiden

Address: ____
Street Apt. # City State Zip

Phone: Home: ______________ Work: ______________ Age: ______ Gender: ______

Emergency Contact: ____________________ Phone: __________________ Relationship: __________

Referred by: ___ Self ___ Family ___ Friend ___ Primary care ___ Other healthcare professional

Name of person making referral: ____

Name of primary care provider: ____

Do you have an orthopedic surgeon? ____ Yes ____ No If yes, name: ____________________

Preferred pharmacy: ____

Allergies and reactions: ____

Date of last: Flu vaccine _______ Pneumonia vaccine _______ Shingles vaccine _______

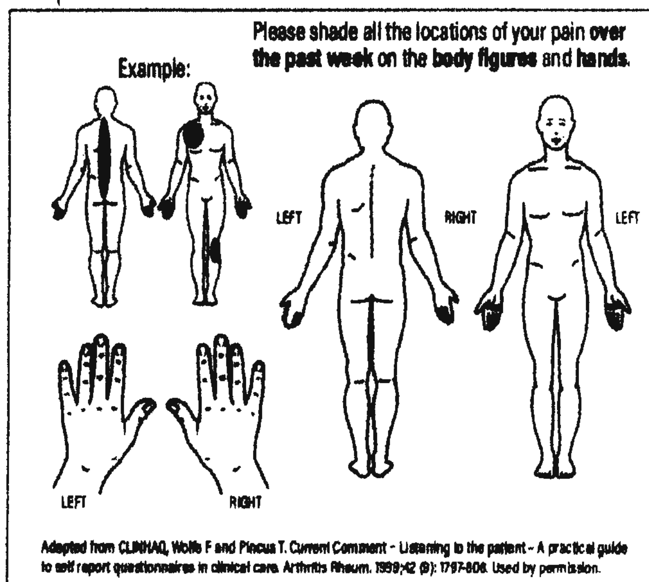
Briefly describe your present symptoms: ______________________

Date symptoms began: ______________________

Diagnosis: ______________________

Previous treatments (PT, surgery, injections – meds listed separately): ______________________

Other providers that have treated this concern:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

Family History:

	Relative		Relative
Diabetes		Fibromyalgia	
Cancer		Osteoporosis	
Crohn's/Ulcerative Colitis		Rheumatoid Arthritis	
Psoriasis		Gout	
Ankylosing Spondylitis		Celiac Disease	

Social History:

Marital Status: ____ Never Married ____ Married ____ Divorced ____ Separated ____Widowed
Spouse/Significant other: Alive/age:____ Deceased/age:____ Major illnesses:____________________
Number of children: ______ Number of children living at home: ______
Education: (Circle highest level attended)
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School: ______________
Occupation: ____________________ Hours worked/week: ________ On disability? ________
Caffeine intake: ____________________
Alcohol intake: ____________________ Has anyone ever asked you to cut down on drinking? ________
Are you a smoker? ___ Yes ___ No ___ Past - how long ago did you quit? __________
Do you use drugs for non-medical reasons? ___ Yes ___ No If yes, please list: ____________________

Do you exercise regularly? ___ Yes ___ No
Type: ____________________ Times per week: ____________________
How many hours of sleep do you get per night? _______
Do you get enough sleep at night? ___ Yes ___ No Do you wake up feeling rested? ___ Yes ___ No
Do you feel safe in your home environment? ___ Yes ___ No
Is your sex life satisfactory? ___ Yes ___ No Elaborate: ____________________

Surgical History:

Procedure	Year	Reason

Past Medical History:

		Year	Resolved ?			Year	Resolved?
Rheumatic Fever				Uveitis, Iritis			
Tuberculosis				Cancer - type?			
Hepatitis				Food poisoning			
HIV				Osteoporosis			
Gonorrhea				Fracture			
Chlamydia				Mental Illness			

Elaborate, if necessary: ____
____

Reclast						
Prolia						
ANTI-CONVULSANTS						
Gabapentin (Neurontin)						
Lamictal (Lamotrigene)						
Lyrica (Pregabalin)						
Topamax (Topiramate)						
MUSCLE RELAXANTS						
Baclofen (Lioresal)						
Carisoprodol (Som)						
Cycloenzaprine (Flexeril)						
Methocarbamol (Robaxin)						
Metaxalone (Skelaxin)						
Orphenadrine (Norflex)						
Tizanadine (Zanaflex)						
ANTIDEPRESSANTS						
Amitriptyline (Elavil)						
Bupropion (Wellbutrin)						
Buspironne (Buspar)						
Citalopram (Celexa)						
Duloxetine (Cymbalta)						
Escitalopram (Lexapro)						
Fluoxetine (Prozac)						
Milnacipran (Savella)						
Nortriptyline (Pamelor)						
Paroxetine (Paxil)						
Velazodone (Viibryd)						
Venlafaxine (Effexor)						
OTHERS						
Cortisone (Prednisone)						
Supplements						
Hyalgan, Euflexxa, Synvisc, etc.						

Patient Registration Form

PERSONAL INFORMATION

Name: ______________________________ Date of Birth: _______________ Social Security #: ______________

Address: ______________________________ City: ____________________ State: ________ Zip: ___________

Home Phone: _________________ Work Phone: _________________ Cell/Alternate Phone: _________________

Email Address: ____________________________________

Race (Please circle all that apply): American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Some Other Race, Declined, Unavailable

Ethnicity (Please circle all that apply): Hispanic or Latino, Non-Hispanic or Latino, Declined, Unavailable

Preferred language: ___________________________

INSURANCE INFORMATION

Please inform the staff of any insurance changes as soon as possible

Primary Insurance Company: ________________________ Subscriber Name: _____________________

Contract/Policy#: _______________________________ Group #: _______________ Co-pay: ____________

Subscriber Date of Birth: ____________________

Secondary Insurance Company: _____________________ Subscriber Name: ______________________

Contract/ Policy #: _______________________________ Group#: _______________ Copay: ____________

Subscriber Date of Birth: ____________________

FOR THIRD INSURANCE-PLEASE WRITE IN POLICY/ SUBSCRIBER INFORMATION IN THE BACK OF THIS FORM

EMERGENCY CONTACT INFORMATION

Name: _________________________ Phone: __________________ Relationship to Patient: ____________

REFFERAL INFORMATION

Referring Physician: ____ Phone: __________________________

Primary Care Physician (if different from referring): ________________________ Phone: ______________________