Texoma Arthritis Clinic, P.A.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

our facilities and our website at ww.texomaarthritis.com. You can get a copy of the current privacy notice at any time.

Complaints and Appeals

You may contact the Texoma Arthritis Clinic, P.A. Privacy Officer if:

- You think that you privacy rights may have been violated
- You disagree with our decision about access to your records
- You disagree with our decision not to correct your record

We will not publish you in any way for filing a complaint. You may also send a written complaint to the U.S. Department of Health and Human Services' Office of Civil Rights.

Privacy Officer
1445 Heritage Drive Suite A
McKinney, Texas 75069
Phone (972)547-9700 ext 1300

Office of Civil Rights
US Department of Health and Human Services
1961 Stout Street #1428
Denver, Colorado 80294
(Cannot phone)

Other Ways That Information about You May be Used

Unless you tell us not to, we may use information that we have about you to:

- List you in our hospital directory and give your room number and your status (good, fair, etc.) to those who ask for you by name
- Tell a clergy member of your religion (even if the clergy does not ask for you by name)
- Remind you of an appointment
- Recommend possible treatment options
- Tell you about health-related services
- Raise money for our hospital or any of our other facilities

If you do not want your information to be used for fundraising or marketing, please notify the Texoma Arthritis Clinic, P.A. Privacy Officer in writing

Uses and Disclosures That Require Your Authorization

In any other situation not covered by this notice, we will get your written authorization before using or sharing your health information, including release of psychotherapy records. You may revoke any authorization in writing.

Your Rights Regarding Medical Information about You

In most cases, you may review and obtain a copy of your medical record. There may be a fee for the cost to copy and mail it. Your request must specify how or where you wish to receive your medical record. We will honor all reasonable requests.

You may ask us to correct your record if you think that it is incorrect or that key information is missing. You must put your request in writing and state the reason for your request. We cannot revise your record if the information was not created by us; or is not part of the medical record we maintain; or is not part of the record that you can review or copy; or if we find out that the record is accurate.

You may get a list of when and to whom we agave your medical information. Such a list would not include the permitted disclosures outlined within this notice. Your written request for such a list must state a time period; it must start after April 14, 2003 and be within six years. The first list in a 12 month period is free; other request will include a fee for our cost to produce the list. We will inform you of the cost before we process your request.

You may ask that we communicate medical information about you in a confidential way, such as sending mail to an address other than your home. We will honor all reasonable requests. Our waiting areas and some of our treatment areas, such as in our physical therapy department, is shared with other patients. Please tell us if you object to this type of waiting or treatment areas. We will do our best to accommodate your request for privacy.

You may ask that we not use or disclose a certain part of your information as allowed by this notice unless you sign consent to release the information. By law, we do not have to accept such a request, but we will seriously consider it and inform you of our decision. Your request must tell us what specific information you want to limit and to whom the limits apply.

Changes to Texoma Arthritis Clinic, P.A. Privacy Notice

We may change our privacy policies at any time. Changes will apply to prior and new medical information. Before we make major changes in our policies, we will change our Notice of Privacy Practices and post the new notice in

Texoma Arthritis Clinic, P.A. HIPAA Statement

Texoma Arthritis Clinic, P.A. is committed to respecting the privacy of our patients and maintaining the confidentiality of their protected health information. When you consent to treatment of Texoma Arthritis Clinic, P.A., you consent to the use of your information as outlined in our Notice of Privacy Practices. If we decide to change our notice, such changes will be posted here on our website. You may visit our website and browse without giving us and personal information.

If you have any questions or comments regarding our Privacy Policies or the security of your information, please call (972)547-9700 ext. 1300 and that will connect you to our Privacy Officer Holli Engels.

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

Our Pledge to You

The health care providers at Texoma Arthritis Clinic, P.A. create a detailed record of the care and services you receive at our facilities. By law, we must keep this record private and we must give you this summary of our legal duties and privacy practices, and follow them. Our policies apply to all of the records of your care that Texoma Arthritis Clinic, P.A. maintains.

Who Will Follow These Privacy Practices

Texoma Arthritis Clinic, P.A. provides health care in partnership with physicians, other health-care providers and agencies. These privacy practices will be followed by:

- Any health care provider who treats you at any of our locations
- All board members, employees, staff and volunteers of our organization
- All members of our Organized Health Care Arrangement (members of our Medical Staff and Allied Health Practitioners such as Nurse Midwives and Nurse Practitioners)
- Any business associate or partner who agrees to maintain your privacy

Some Ways Your Medical Record May be Used or Shared

We may use or share medical information about you:

- For treatment, such as a referral to a specialist or other health care agency
- For payment, such as your insurance company, Medicare
- For health care functions, such as to improve our services
- For regulatory agencies, such as during an audit or survey of our facilities
- With those whom you designate to be involved in your care
- In an emergency or disaster, so that your family or friends can be told where you are and how you are
- When required for public health reports, abuse or neglect reports, funeral arrangements, and organ donation
- When required by law, such as a request from law enforcement or a legal order
- When required by military authorities, if you are a member of the military or a veteran
- For nation security and intelligence activities, or for the protection of the President or others

Assignment of Benefits

Texoma Arthritis Clinic, P.A.
1445 Heritage Drive Suite A
McKinney, Texas 75069
Phone: (972) 547-9700

Date: _____
Patient: _____
Ins. ID #: _____
Group #: _____

I, _____ understand that services rendered to me by Texoma Arthritis Clinic, P.A. are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Texoma Arthritis Clinic, P.A. and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize Texoma Arthritis Clinic, P.A. to release any information necessary to adjudicate the claim and the understanding that there may be associated costs for providing information beyond what is necessary for the adjudication for a clean claim.

I also understand that should my insurance company send payments to me, I will forward the payment to Texoma Arthritis Clinic, P.A. within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collection process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event I, as the patient, receive any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owned by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Sign (Patient/ Parent/Legal Guardian): _____ Date: _____

Signature of Policyholder: _____ Date: _____

Witness: _____ Date: _____

by the doctor. If we do not participate with your insurance company or if you do not have health insurance coverage, payment for services is due in full at the time services are rendered (unless our office manager has approved special arrangements). All out-of network or self pay patients have a $200.00 deposit at the time of check in.

5. Any returned checks are subject to a $25.00 service fee. Any returned check must be resolved before any future appointments can be arranged.
6. For minor age patients, treatment will be denied unless accompanied by an adult. The adult accompanying the minor will be responsible for any payment due on the account.
7. So as not to tie our office staff up with prescription refill request, please be sure to ask the doctor for your prescriptions at the time of your visit.

INSURANCE

As a courtesy to you, we will bill your insurance company if we are a participating provider. If we do not participate with our insurance plan, you will be responsible for the cost of the office visit and any procedures performed. *Payment is due at time of service.* It is the ultimate responsibility of the patient to understand his/her coverage. Our staff cannot call your insurance company at the time of your visit to obtain information about your benefits. Insurance policies may change and/or insurance company representatives do not always give us correct or consistent information. *In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered.*

We thank you for understanding our financial policies. This has become necessary in order to continue to accept insurance plans without having patients pay the balance up front and then wait themselves for reimbursement from their insurance company. Our goal is to make your visit with us a pleasant and professional experience. If you have any questions, please feel free to ask our staff for assistance. Thank you again for choosing TEXOMA ARTHRITIS CLINIC, P.A. for your care.

Sign (Patient/ Parent/Legal Guardian): _____ Date: _____

WELCOME TO TEXOMA ARTHRITIS CLINIC, P.A.

Our goal is to provide you with quality care in a friendly, comfortable atmosphere and in as timely a manner as possible. This information is designed to guide you through the rapidly changing world of medicine, managed care, and insurance plans. Please understand that payment of your bill is considered part of your treatment. *We accept cash, check, credit & debit cards, and money orders.* Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.

GENERAL OFFICE RULES

We believe your time is as valuable as ours. We do not overbook patients excepts in cases of emergency and we do our best to stay on schedule to avoid any delays to you. Please assist us in our efforts to stay on time in the following ways. If you are more than 15 minutes late it may be necessary to reschedule your appointment for a later time.

1. If you are a new patient, please arrive 30 minutes early to allow for time to fill out necessary medical and insurance information. If paperwork was mailed, faxed, or you got it off our website in advance, please bring the completed forms as well as your insurance and driver's license to the office on the day of your appointment.
2. If you are an established patient, please have a copy of insurance with you at the time of appointment.

Our receptionist will be required to keep patient information as up to date as possible. Please understand that we may ask you for any change of address or phone number on subsequent visits. This information helps us to better serve you.

3. Please realize that it is each individual's responsibility to keep track of appointments made. If you need to cancel or reschedule and appointment, please give us a 24 hour notice so that we may schedule another patient in the time slot reserved for you. On occasion you may not receive a reminder call, text, or email. If you do not cancel your appointment 24 hours in advance, a $25.00 fee will be charged for established patients and a $50.00 fee for new patients (except in cases of emergencies or illness) and will be payable prior to future visits.
4. If you have a managed care medical insurance that we participate with, your payment of deductibles and non-covered services are due when services are rendered. All co-payments are due before you will be seen

PERMISSION TO GIVE MEDICAL INFORMATION & EMERGENCY CONTACT

I, _____ hereby authorize the physicians and staff of TEXOMA ARTHRITIS CLINIC, P.A. to give the following people information about my health and well being.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

The following information may be given:

	People listed above	Answering Machine
Appointment Time	yes or no	yes or no
Test/Lab Results	yes or no	yes or no
Medications	yes or no	yes or no
Procedures	yes or no	yes or no
Any info. not listed above regarding my health	yes or no	yes or no

In case of an Emergency you may contact:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Sign (Patient/ Parent/Legal Guardian): _____ Date: _____

Witness: _____ Date: _____

Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neroal		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Humira		☐	☐	☐	
Simponi		☐	☐	☐	
Cimzia		☐	☐	☐	
Stelara		☐	☐	☐	
Cosentyx		☐	☐	☐	
Rituxan		☐	☐	☐	
Orencia		☐	☐	☐	
Osteoporosis Medications					
Estrogen(premarin, etx.)		☐	☐	☐	
Alendronate(Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Flouride		☐	☐	☐	
Calcitonin injection or nasal (miacalcin, calcimar)		☐	☐	☐	
Risendronate (actonel		☐	☐	☐	
Prolia		☐	☐	☐	
Reclast/Zolendronic Acid		☐	☐	☐	
Gout Medications:					
Probenecid (Benemid)		☐	☐	☐	
Colchidine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Uloric		☐	☐	☐	
Other:		☐	☐	☐	
Others:					
Tamoxifen(Nolvadex		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hayalgan/Synvisc injections		☐	☐	☐	
Euflexxa		☐	☐	☐	
Orthovisc/Monovisc		☐	☐	☐	
Herbal or Nutritional Supplenents		☐	☐	☐	
Please list Supplements:					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No

If yes, List:

Are you applying for disability? ..... ☐ Yes ☐ No
Do you have a medically related lawsuit pending? ..... ☐ Yes ☐ No

Activities of Daily Living

Do you have stairs to climb? __Yes __No, If yes, how many? _____
How many people in household?_____Relationship and age of each_____

Medications

Drug allergies: __Yes__No if yes, to what?_____

_____

Please list any medications you are currently taking, include such items as aspirin, vitamins, laxatives, calcium, and other supplements, etc.

Name of Drug	Dose (include strength & number of pills per day	How long have you taken this medication?	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

Past Medications? 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, ther results of taking the medication and list any reactions you may have had. Record your comments in the spaces provided.

Drug names/dosage	Length of time	Please check: helped?			Reactions
		A lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory drugs (NSAIDS)		☐	☐	☐	
Ansaid(Ibuprofen) Arthritec(diclofenac + misoprostil) Aspirin (including coated aspirin) celebrex (celecoxib) Clinoril(sulindac) Daypro (oxaprozin) Disalcid (salsalate) (Dolobic (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Maclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nelfon (fenoprofen) Naprosyn (naproxen) Onuvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers:					
Acetaminoophen (Tylenol		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Hydroxychloroquine (Plaquenil		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	

Multi-Dimensional Health Assessment Questionnaire (HAQ/ R808-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are not right or wrong answers. Please answer exactly as you think you feel.

1. Please check (√) ONE answer, to the best of your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to Do
a. Dress yourself, including tying shoelaces & doing buttons	0	1	2	3
b. Get in and out of bed	0	1	2	3
c. Lift a full cup or glass to your mouth	0	1	2	3
d. Walk outdoors on flat ground	0	1	2	3
e. Wash and dry your entire body	0	1	2	3
Bend down to pick up clothing from the floor	0	1	2	3
g. Turn regular faucets on and off	0	1	2	3
h. Get in and out of a vehicle, train, or plane	0	1	2	3
i. Walk 2 miles/3 kilometers, if you wish	0	1	2	3
j. Participate in recreational activities and sports	---	---	---	---
---	0	1.1	2.2	3.3
k. Get a good night's sleep	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous	0	1.1	2.2	3.3

For Office Use Only

1-j FN (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10):

4. PTGL (0-10):

RAPID 3 (0-30):

CAT:
HS = >12
MS = 6.1-12
LS = 3.1-6
R = ≤3

2. How much pain have you had because of your condition OVER THE PAST WEEK?
Please indicate below how sever your pain has been:

NO PAIN 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 PAIN AS BAD AS IT COULD BE

3. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint area listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. Left Fingers					a. Right Fingers				
b. Left Wrist					b. Right Wrist				
c. Left Elbow					c. Right Elbow				
d. Left Shoulder					d. Right Shoulder				
e. Left Hip					e. Right Hip				
f. Left Knee					f. Right Knee				
g. Left Ankle					g. Right Ankle				
h. Left Toes					h. Left Toes				
i. Neck					i. Back				

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 VERY POORLY

Are you receiving disability? ..... ☐ Yes ☐ No

Past Medical History:

Do you now or have you ever had: (check if "yes")

- ☐ Cancer
- ☐ Goiter
- ☐ Cataracts
- ☐ Nervous breakdow
- ☐ Bad headaches
- ☐ Kidney disease
- ☐ Anemia
- ☐ Emphysema
- ☐ Heart problems
- ☐ Leukemia
- ☐ Diabetes
- ☐ Stomach ulcers
- ☐ Jaundice
- ☐ Pneumonia
- ☐ HIV?ADIS
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Asthma
- ☐ Stroke
- ☐ Epilepsy
- ☐ Rheumatic fever
- ☐ Colitis
- ☐ Psoriasis
- ☐ High blood pressure
- ☐ Tuberculosis
- ☐ Hypothyroidism

Other significant illness (please list): _____

_____

Natural or AlternativeTherapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Social History:

Do you drink caffeinated beverages?

Cups/Glasses per day? _____

Do you smoke? ☐ Yes ☐ No Past- How long ago? _____

Do you drink alcohol? ☐ Yes ☐ No Number per week _____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical?

☐ Yes ☐ No... If yes, please list: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

Type: _____

Amount per week: _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ☐ Yes ☐ No

Do you wake up feeling rested? ☐ Yes ☐ No

Previous Operations:

Type:	Year:	Reason:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Family History:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings_____ Number living _____ Number deceased_____

Number of children_____ Number living_____ Number deceased_____ List ages of each:_____

Health of children_____

_____

Do you know of any blood relative who has or had: (check and give relationship):

- ☐ Cancer_____
- ☐ Heart disease_____
- ☐ Rheumatic fever_____
- ☐ Tuberculosis_____
- ☐ Leukemia_____
- ☐ High blood pressure_____
- ☐ Epilepsy_____
- ☐ Diabetes_____
- ☐ Stroke_____
- ☐ Bleeding tendency_____
- ☐ Asthma_____
- ☐ Goiter_____
- ☐ Colitis_____
- ☐ Alcoholism_____
- ☐ Psoriasis_____

Review of Systems:

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram: ___/___/____ Date of last eye exam: ___/___/____ Date of last chest x-ray: ___/___/____

Date of last tuberculosis test: ___/___/___ Date of last bone densitometry: ___/___/____ Date of last flu shot ___/___/____

Date of last tetanus shot: ___/___/____ Date of last pneumonia shot: ___/___/____

Constitutional:

- ☐ Recent weight gain
  Amount _____
- ☐ Recent weight loss
  Amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

Eyes:

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness
- ☐ Feels like something in eye
- ☐ Itching eyes

Ears-Nose-Mouth-Throat:

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Dryness in nose
- ☐ Runny nose
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing

Cardiovascular:

- ☐ Pain in chest
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory:

- ☐ Shortness of breath
- ☐ Difficulty in breathing at night
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing (asthma)

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting of blood or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ Jaundice
- ☐ Increase constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn
- ☐ Hepatitis infection

Genitourinary:

- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Blood in urine
- ☐ Cloudy, "smoky" urine
- ☐ Pus in urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to pass urine
- ☐ Vaginal dryness
- ☐ Rash/ulcers
- ☐ Sexual difficulties
- ☐ Prostate trouble

For women only:

Age when periods began: _____

Regular period? ☐ Yes ☐ No

How many days apart? _____

Date of last period: ___/___/____

Date of last pap? ___/___/____

Bleeding after menopause? ☐Yes☐No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal:

- ☐ Morning stiffness
  Lasting how long? _____
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
  List joints affected: _____
  _____

Integumentary (skin and/or breast):

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive(sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet in the cold

Neurological system:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Night sweats
- ☐ Seizures

Psychiatric:

- ☐ Excessive worries
- ☐ Anxiety
- ☐ Easily losing temper
- ☐ Depression
- ☐ Agitation
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

Endocrine:

- ☐ Excessive thirst

Hematologic/Lymphatic:

- ☐ Swollen glands
- ☐ Tender glands
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Transfusion/when_____

Allergic/immunologic:

- ☐ Frequent sneezing
- ☐ Increase susceptibility to infection

Texoma Arthritis Clinic, P.A.
1445 Heritage Dr. Suite A
McKinney, TX 75069
Patient History Form

Date of first appointment: ____/____/____ Time of appointment: _____ SSN: _____

Name: _____ Birth date: ____/____/____
LAST FIRST MIDDLE INITIAL MAIDEN

Address: _____ Age: _____ Sex: ☐ F ☐ M

_____ Telephone: Home: (____)_____*
CITY STATE ZIP CODE

Cell phone: (____)_____*

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/ Significant Other: ☐ Alive/Age____ ☐ Deceased/Age_____ Major Illnesses: _____

Occupation: _____

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

Name of person making referral/Telephone #: _____

Name of Primary Care Provider/Telephone #: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms started (approximate): _____

_____

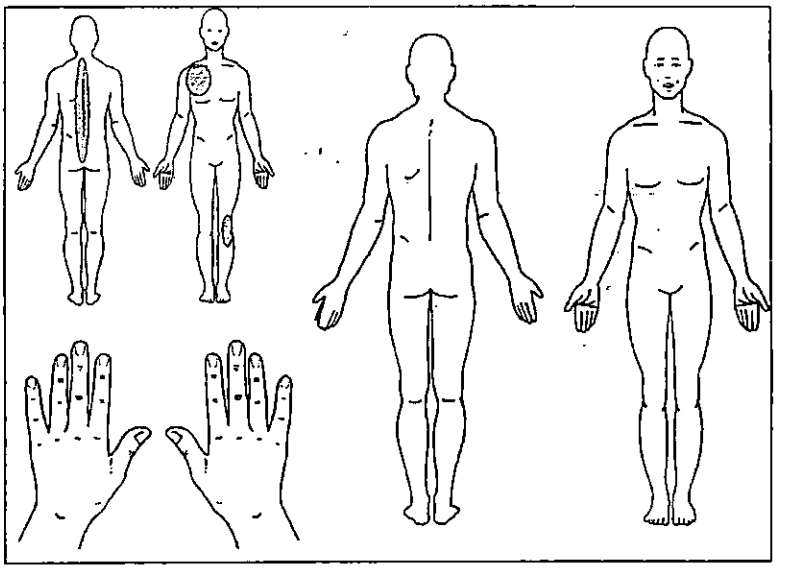
Previous treatments for problem: (include physical therapy surgery and injections): _____

_____

_____

Please list names of other practitioner you have seen for this problem: _____

In image below shade all the locations of pain over past week:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

		Relationship/Name			Relationship/Name
	Arthritis(unknown type)			**Lupus or "SLE"**	
	Osteoarthritis			**Rheumatoid Arthritis**	
	Gout			**Ankylosing Spondylitis**	
	Childhood arthritis			**Osteoporosis**	
Other arthritis conditions:					