Rheumatology and Internal Medicine Associates PC

64-C Concord Street, Wilmington, MA 01887

Phone: (978) 988-9700 Fax: (978) 988-9701

Web: www.rimamd.com E-Mail: staff@rimamd.com

Sharon A. Stotsky, M.D.
Internal Medicine/Rheumatology

Joanne Blouin, PA-C
Amy McCarron, DNP,NP-BC
Holly Nguyen, PA-C

Dear____

Your appointment is on ________________________, at________________.

Thank you for choosing our office for your rheumatology evaluation. Our office is located at 64-C Concord Street in Wilmington. From route 93, take exit 39 – Concord Street Exit. Take a right at the end of the ramp and then take your first left onto Fordham Road. Take your 2ND left into our parking lot. We are in Suite C.

Enclosed are forms which will assist in evaluating your problem. These forms must be filled out and returned to our office one week prior to your appointment. If we do not receive your completed paperwork by the required date, your appointment will automatically be cancelled. Please be advised that consultations are very involved, therefore, you could be at our office for 2-3 hours so please plan accordingly.

If your insurance requires a referral, you must contact your primary care physician and have the referral prior to your visit. Also, please bring your insurance card(s), along with your Drivers License or photo ID to your visit.

At least 48-hour notice for cancellations is appreciated so that we may accommodate those who are on our cancellation list. You may notify us by calling our office, leaving a message with our answering service, or by e-mail at: staff@rimamd.com

To help manage our cancellation list, please check which days/times you would most likely be able to come for an earlier appointment:

	Monday	Tuesday	Wednesday	Thursday	Friday
A.M.	☐	☐	☐	☐	☐
P.M.	☐	☐	☐	☐	☐

How much notice would you need? __________ minutes, hours, days (please circle one)

What is the best phone number to reach you at: ______________________________

The building is handicapped accessible. If you feel you will need assistance with a wheelchair, or will need the use of one once here, please inform our staff when we call to confirm your appointment.

Sincerely,
Sharon Stotsky, M.D.

Rheumatology & Internal Medicine Associates
PLEASE REVIEW, PROVIDE CORRECTED OR MISSING INFORMATON, AND SIGN

PATIENT INFORMATION

Patient:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex: Race:**
City:	**Language:**
State: Zip:	**Marital Status:**
Home Phone#:	**Employer:**
Work Phone#:	**Occupation:**
Cell Phone#:	**Emergency Contact:**
Spouse:	**Emergency Phone#:**
Spouse Phone#:	**Emergency Relationship:**

OTHER INFORMATION

Drugstore:	**Drugstore Phone**
Primary Care Physician:	**Primary Care Physician Phone#:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State: Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber 1 Birthday:	**Subscriber 2 Birthday:**
Workers Comp? (circle 1) Yes No	**If W/Comp give Case# at Check In**

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to my physician all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand I am financially responsible for all charge incurred and am responsible for obtaining a valid referral, if needed. I further acknowledge that my insurance benefits, when received by and paid to my physician to be applied to my account, in accordance with above said assignment. I authorize the release of medical information to my insurer. I also request payment of authorized Medicare/government benefits to be made on my behalf to my physician for any services furnished by that physician.

X______________________________ ____________
Authorized Signature of Subscriber/Patient Date

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Jennifer Damitsian, NP
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CONSENT FORM

Patient Name: Patient #: Date of Birth:

I GIVE MY PERMISSION to discuss my medical information with persons listed below, (please do not include physicians):

Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

*This **DOES NOT INCLUDE** any SENSITIVE information, but allows to call regarding appointments, scheduled tests, and to discuss other pertinent information.*

I DO NOT GIVE MY PERMISSION for you to speak to anyone regarding my medical information.

The best way to contact me is ______________________________, and I understand that is my responsibility to inform Dr. Stotsky's office if this number or email address changes.

I GIVE MY PERMISSION to leave messages on my answering machine.

IF YOUR PHONE DOES NOT ACCEPT BLOCKED NUMBERS, WE WILL BE UNABLE TO REACH YOU.

______________________________ ______________________

Signature **Date**

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Patient's Name: ______________________________ Date: ______________

MEDICATION LIST

Please list all medications you are currently taking (from ALL physicians you are seeing).
Please include aspirin, vitamins, and/or herbal extracts.

Name of Medication and/or Supplement	*What strength?*	*How often do you take it?*	*What do you take it for?*	*Date Changed*

Dates reviewed and initials

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PATIENT HISTORY FORM

Date of your first appointment: ______/______/______ Time of your appointment: ____________
MONTH DAY YEAR

Primary Care Physician (PCP) Name: ____________ PCP Phone: (____)______

PCP Address: ____________

Your Name: ____________
LAST FIRST MIDDLE INITIAL MAIDEN

Birthdate: ______/______/______ Birthplace: ____________ Age: ______ Sex: ☐ Female ☐ Male
MONTH DAY YEAR

MARITAL STATUS: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/Significant Other: ☐ Alive/Age ______ ☐ Deceased/Age ______ Major Illnesses of Spouse ____________

EDUCATION (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School ____________

Occupation ____________ Number of hours worked/average per week ______

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

Name of person making referral: ____________

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

Describe briefly your present symptoms: ____________

Date symptoms began (approximate): ____________

Diagnosis: ____________

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

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

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands** or if you have psoriasis please color in affected areas.

Example:

LEFT RIGHT LEFT

LEFT RIGHT

RHEUMATOLOGIC (ARTHRITIS) HISTORY:

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

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

SOCIAL HISTORY:

Do you drink caffeinated beverages? ☐ Yes ☐ No

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

Who does most of the housework? ______

Who does most of the shopping? ______

What is the hardest thing for you to do? ______

PAST MEDICAL HISTORY:

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

☐ Anemia
☐ Asthma
☐ Bad Headaches
☐ Cancer
☐ Cataracts
☐ Colitis
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Frequent Infections
☐ Glaucoma
☐ Goiter
☐ Heart Problems
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Jaundice
☐ Kidney Disease
☐ Nervous Breakdown
☐ Pneumonia
☐ Positive TB Test
☐ Psoriasis
☐ Rheumatic Fever
☐ Stomach Ulcers
☐ Stroke
☐ Tuberculosis

Other significant illness (please list): ______

______

Number of people in household: ______

Relation and Age: ______

______

Are receiving disability? ☐ Yes ☐ No

Are you applying for disability? ☐ Yes ☐ No

Do you have a medically related lawsuit pending? ☐ Yes ☐ No

PREVIOUS OPERATIONS:

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			

Any previous fractures? ☐ No ☐ Yes Describe: ______

Any other serious injuries? ☐ No ☐ Yes Describe: ______

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: ______

______ # of Grandchildren: ______

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

☐ Alcoholism ______
☐ Asthma ______
☐ Bleeding Tendency ______
☐ Cancer ______
☐ Colitis ______
☐ Diabetes ______
☐ Epilepsy ______
☐ Goiter ______
☐ Heart Disease ______
☐ High Blood Pressure ______
☐ Leukemia ______
☐ Psoriasis ______
☐ Rheumatic Fever ______
☐ Stroke ______
☐ Tuberculosis ______

Patient's Name: Date: Physician Initial

SYSTEMS REVIEW

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: ____/____/____

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 heartbeat
- ☐ 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
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools
- ☐ Heartburn

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: ____________

Periods regular? ☐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?
  ________ Minutes ________ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling

List joints affected in the last 6 months:

____

____

____

____

____

Integumentary (skin and/or breast)

- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color change 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

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
- ☐ Increased susceptibility to infection

Patient's Name: ______________________ Date: ____________ Physician Initials: ________

ACTIVITY LEVEL

1. Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 *Very Poorly*

2. How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 *Pain as Bad as it Could Be*

Please answer the following questions, even if you feel that they may not be related to you at this time.
Answer exactly as you think or feel – there are no right or wrong answers. Check the one best answer for each question

Right now, are you able to:	*Without Difficulty*	*With Some Difficulty*	*With Much Difficulty*	*Unable To Do*
1. Dress your yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
2. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
3. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
4. Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
5. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
6. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
7. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
8. Get in and out of a car, bus, train or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
9. Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
10. Participate in sports and play games as you like?	☐ 0	☐ 1	☐ 2	☐ 3
11. Get a good night's sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
12. Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
13. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

MEDICATIONS

Drug Allergies: ☐ No ☐ Yes To what? ____________________

____

Type of reaction? ____________________

____

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

Drug Name/Dosage	*Length of Time*	*Please Check: Helped?* *A Lot*	*Some*	*Not At All*	*Reactions*
Cortisone/Prednisone/Solumedrol/Medrol					
Hyalgan/Synvisc					
Lidoderm Patch					
Supartz/Orthovisc					
Disease Modifying Antirheumatic Drugs (DMARDs)					
Amevive (alefacept)					
Arava (leflunomide)					
Atabrine (quinacrine)					
Azulfidine (sulfasalazine)					
Cuprimine, Depen (penicillamine)					
Cytoxan (cyclophosphamide)					
Enbrel (etanercept)					
Humira (adalimumab)					

continues on next page

Patient's Name: ____________________ Date: ____________ Physician Initials: ____________

PAST MEDICATIONS continued...

Drug Name/Dosage	Length of Time	Please Check: Helped? A Lot	Some	Not At All	Reactions
Disease Modifying Antirheumatic Drugs (DMARDs) continued					
Imuran (azathioprine)					
Kineret (anakinra)					
Myochrysine, Solganol, Aurolate (gold shots)					
Orencia (abatacept)					
Plaquenil (hydroxychloroquin)					
Prosorba Column (apheresis)					
Raptiva (efalizumab)					
Remicade (infliximab)					
Rheumatrex (methotrexate)					
Ridaura (auranofin, gold pills)					
Rituxan (rituximab)					
Sandimmune, Neoral, Gengraf (cyclosporine A)					
Herbal or Natural Supplements *(please list)*					

Gout Medications (circle any you have taken in the past)

Benemid (probenecid)
Colchicine
Zyloprim/Lopurin (allopurinol)

Muscle Relaxants (circle any you have taken in the past)

Dantrium (dantrolene sodium)
Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)
Zanaflex (tizanidine)

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (circle any you have taken in the past)

Ansaid (flurbiprofen)
Arthrotec (diclofenac + misoprostol)
Aspirin (including coated aspirin)
Bextra (valdecoxib)
Celebrex (celecoxib)
Clinoril (sulindac)
Disalcid (salsalate)
Daypro (oxaprozin)
Dolobid (diflunisal)
Feldene (piroxicam)
Indocin (indomethacin)
Lodine (etodolac)
Meclomen (meclofenamate)
Mobic (meloxicam)
Motrin/Rufen/Advil (ibuprofen)
Nalfon (fenoprofen)
Naprosyn/Aleve (naproxen)
Oruvail (ketoprofen)
Relafen (nabumetone)
Tolectin (tolmetin)
Toradol (ketorolac tromethamine)
Trilisate (choline magnesium trisalicylate)
Vioxx (rofecoxib)
Voltaren (diclofenac)

Osteoporosis Medications (circle any you have taken in the past)

Actonel (risedronate)
Aredia (pamidronate)
Boniva (ibandronate sodium)
Didronel (etidronate)
Estrogen (Premarin, etc.)
Evista (raloxifene)
Fluoride
Forteo (teriparatide)
Fosamax (alendronate)
Miacalcin, Calcimar (calcitonin inject/nasal)
Reclast (zoledronic acid)

Pain Relievers (circle any you have taken in the past)

Avinza (morphine sulfate)
Codeine (Tylenol 3)
Darvon/Darvocet (propoxyphene)
Dilaudid (hydromorphone hydrochloride)
Dolophine (methadone)
Duragesic Patch (fentanyl)
Kadian (morphine sulfate)
Lortab (hydrocodone + acetaminophen)
Lyrica (pregabalin)
MS Contin (morphine)
Neurontin (gabapentin)
Oxycontin (oxycodone HCl)
Percocet (oxycodone + acetaminophen)
Percodan (oxycodone + aspirin)
Roxicodone (oxycodone)
Suboxone (buprenorphine)
Tylenol (acetaminophen)
Ultram (tramadol)
Vicodan (hydrocodone + aspirin)
Vicodin (hydrocodone + acetaminophen)
Vicoprofen (hydrocodone + ibuprofen)
Other Narcotic

Psychotherapeutic Agents (circle any you have taken in the past)

Abilify (aripiprazole)
Adderall (amphetamine)
Ativan (lorazepam)
Buspar (buspirone)
Celexa (citalopram)
Clozaril (clozapine)
Concerta (methylphenidate)
Cymbalta (duloxetine)
Depakote (divalproex)
Desoxyn (methamphetamine)
Effexor (venlafaxine)
Elavil (amitriptyline)
Geodon (ziprasidone)
Haldol (haloperidol)
Klonopin (clonazepam)
Lamictal (lamotrigine)
Lexapro (escitalopram)
Librium (chlordiazepoxide)
Lithium (Eskalith)
Moban (molindone)
Navane (thiothixene)
Pamelor (nortriptyline)
Paxil (paroxetine)
Provigil (modafinil)
Prozac/Sarafem (fluoxetine)
Remeron (mirtazapine)
Restoril (temazepam)
Risperdal (risperidone)
Ritalin (methylphenidate)
Seroquel (quetiapine)
Serzone (nefazodone)
Sinequan (doxepin)
Strattera (atomoxetine)
Symbyax (thienobenzodiazepine)
Topamax (topiramate)
Tranxene (clorazepate)
Valium (diazepam)
Wellbutrin, Zyban (bupropion)
Xanax (alprazolam)
Zoloft (sertraline)
Zyprexa (olanzapine)

Patient Name: ______________________________ DOB: ____________

Dear Patient:

We are required to collect the following information as part of our Electronic Medical Record Implementation and meeting the Federal Guidelines for Meaningful Use Standards.

Please check off the appropriate box and return to the front desk.

Gender: ☐ Male ☐ Female

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ More than 1 Race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Refused to report/unreported
- ☐ White

Ethnicitv:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to report/ Unreported

Language:
- ☐ English
- ☐ Spanish
- ☐ Other – Please Specify ______________________________

Place of Birth: __________________________

Marital Status: __________________________

Date: __________________ Patient Signature: ________________________

Thank You.