



Mary Washington

Rheumatology

Dear Patient:

Welcome to Mary Washington Rheumatology. We are pleased to have the opportunity to participate in your care. For your convenience, and to help make your first visit go smoothly, please arrive 30 minutes prior to your scheduled appointment and bring the following items with you:

- Completed Patient Intake Packet (enclosed)
- Patient Medical History Form (enclosed)
- Medication List (enclosed)
- Current Insurance Card
- Photo ID
- Insurance Referral
- Insurance Co-pay to be collected at your visit

Our office is located on the 4th floor of the Thompkins Martin Medical Building. Please note, failure to arrive 30 minutes prior to your appointment may result in rescheduling your new patient appointment. You may drop off the enclosed forms at any time prior to your new patient appointment.

If you have any questions or concerns, please contact our office directly at the number listed below.

Thank you for choosing Mary Washington Rheumatology. We look forward to meeting you soon.

Sincerely,

Mary Washington Rheumatology
1101 Sam Perry Blvd., Suite 413
Fredericksburg, VA 22401



Mary Washington

Rheumatology

1101 Sam Perry Blvd., Suite 413
 Fredericksburg, VA 22401
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Patient History Form

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

Name: _____ Date of Birth: ____/____/____
Last First Middle Initial Maiden Month Day Year

Address: _____ Age: _____ Sex: F M
Street APT# City State Zip
 Phone: (home) _____
 (work) _____

Marital Status: Never Married Married Divorced Separated Widowed
 Spouse/Significant Other: Alive/Age ____ Deceased/Age ____ Major Illnesses: _____

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: _____

The name of the physician providing your primary medical care: _____

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 shade all the locations of your pain over the past week on the body figures and hands.
 Example:

Rheumatologic (Arthritis) History

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

Yourselves	Relative Name/Relationship	Yourselves	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood Arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

Patient Name: _____ Date: _____ Physician initials: _____

SYSTEMS REVIEW

As you review the following list, please check any 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 throat
- Hoarseness
- Difficulty swallowing

Cardiovascular

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

Respiratory

- Shortness of breath
- Difficulty 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 stool
- Black stool
- Heartburn

Genitourinary

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

For Women Only:

- Age when period began: _____
- Period 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 miscarriage? _____

Musculoskeletal

- Morning stiffness
Lasting how long?
_____ Minutes _____ Hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling

List joints affected in the last 6 mons.

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

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 Name: _____ Date: _____ Physician initials: _____

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

PAST MEDICAL HISTORY

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Colitis
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	
	<input type="checkbox"/> Asthma	

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.) _____

PREVIOUS SURGERIES		
Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? Yes No Describe: _____

Any other serious injuries? Yes No 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 _____

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

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	

Patient Name: _____ Date: _____ Physician initials: _____

MEDICATIONS:

Drug allergies: Yes No If yes, please list: _____

Type of reaction: _____

Present Medications (List any medications you are 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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 names/Dose	Length of time	Please check: Helped?			Reactions
		A lot	Some	Not at all	
Non-steroidal anti-inflammatory drugs (NSAIDs)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please check any you have taken in the past.

- | | | |
|---|---|---|
| <input type="checkbox"/> Flurbiprofen | <input type="checkbox"/> Naproxen | <input type="checkbox"/> Etodolac |
| <input type="checkbox"/> Oxaprozin | <input type="checkbox"/> Aspirin (including coated aspirin) | <input type="checkbox"/> Choline magnesium trisacrylate |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Piroxicam | <input type="checkbox"/> Sulindac |
| <input type="checkbox"/> Diclofenac + misoprostil | <input type="checkbox"/> Ketoprofen | <input type="checkbox"/> Meclofenamate |
| <input type="checkbox"/> Salsalate | <input type="checkbox"/> Indomethacin | <input type="checkbox"/> Diclofenac |
| <input type="checkbox"/> Fenoprofen | <input type="checkbox"/> Tolmetin | |
| <input type="checkbox"/> Diflunisal | <input type="checkbox"/> Celecoxib | |

Drug names/Dose	Length of time	Please check: Helped?			Reactions
		A lot	Some	Not at all	
Pain Relievers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acetaminophen		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Name: _____ Date: _____ Physician initials: _____

PAST MEDICATIONS: *Continued*

Disease Modifying Antirheumatic Drugs (DMARDs)

Certolizumab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Golimumab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydroxychloroquine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azathioprine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfasalazine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quinacrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclosporine A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etanercept	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infliximab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tocilizumab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Osteoporosis Medications

Estrogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alendronate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etidronate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raloxifene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcitonin injection or nasal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risedronate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Gout Medications

Probenecid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colchicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alloprinol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Others

Tamoxifen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiludronate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyaluronan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbal or Nutritional Supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list supplements:

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

If yes, list: _____

Patient Name: _____ Date: _____ Physician initials: _____

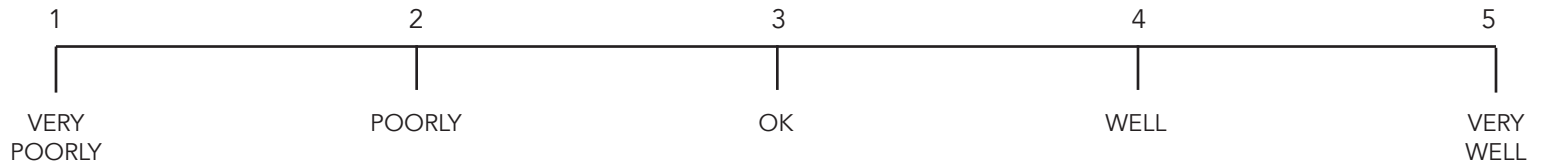
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? Yes No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

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



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, toothbrush, pencil, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, walker or wheelchair? (circle one).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Patient Name: _____ Date: _____ Physician initials: _____