The Center for
RHEUMATOLOGY LLP

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint/Reason for visit: _____

Medication List: Please list all medications, over the counter drugs and supplements you are currently taking.

Name: ex: Folic Acid	**Dosage:** ex: 1mg	**Instructions:** ex: 1 tab daily

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction:** ex: Nausea

Past Medical History: Please check if you or **your immediate family** have a history of any condition below:

	self	family member		self	family member
Alcoholism	☐	☐ _____	Kidney Disease	☐	☐ _____
Anemia	☐	☐ _____	Liver Disease	☐	☐ _____
Autoimmuue Disorder	☐	☐ _____	Lupus	☐	☐ _____
Cancer	☐	☐ _____	Lung Problems	☐	☐ _____
Congestive Heart Failure	☐	☐ _____	Osteoarthritis	☐	☐ _____
Colitis	☐	☐ _____	Osteoporosis	☐	☐ _____
COPD	☐	☐ _____	Psoriasis	☐	☐ _____
Crohn's Disease	☐	☐ _____	Prostate	☐	☐ _____
Depression	☐	☐ _____	Rheumatoid Arthritis	☐	☐ _____
Diabetes	☐	☐ _____	Scleroderma	☐	☐ _____
GERD	☐	☐ _____	Seizures	☐	☐ _____
Gout	☐	☐ _____	Sexually Transmitted Disease	☐	☐ _____
Glaucoma	☐	☐ _____	Stomach Ulcers	☐	☐ _____
Heart Disease	☐	☐ _____	Stroke	☐	☐ _____
High Cholesterol	☐	☐ _____	Thyroid Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____	Tuberculosis	☐	☐ _____
Hepatitis	☐	☐ _____	Pulmonary Hypertension	☐	☐ _____

Other Major Illnesses: _____

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489-4471 | Fax: (518) 489-4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584-4953 | Fax: (518) 584-7916

Queensbury:
17 Main Street | Queensbury, NY 12804
Phone: (518) 584-4953 | Fax: (518) 584-7916

Glenville:
115 Saratoga Rd, # 230 | Glenville, NY 12302
Phone: (518) 344-6369 | Fax: (518) 557-2653

Surgical History: Please list all past operations with dates.

_____

_____

_____

_____

Social History:

Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) ☐ Male ☐ Female

Marital Status: (select one) ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:_____

Race: (select one)
☐ Caucasian ☐ African American ☐ Asian ☐ Native American
☐ Native Alaskan ☐ Native Hawaiian ☐ Pacific Islander ☐ Declined

Ethnicity: (select one) ☐ Hispanic ☐ Non–Hispanic ☐ Declined

Primary Language: (select one) ☐ English ☐ French ☐ Spanish ☐ Other:_____

Occupation:_____ Number of Children:_____
Number of Pregnancies:_____ Number of Miscarriages:_____

Tobacco Use:
☐ Never smoked
☐ Currently smoke every day: Number of packs per day: _____
☐ Currently smoke some days
☐ I have quit smoking: Age when stopped: _____

Alcohol Use:
How many days per week do you drink? _____ How drinks per day? _____
Have you ever had a problem with alcohol? ☐ Yes ☐ No

Illicit / Recreational Drug Use:
Do you use drugs? ☐ Yes ☐ No How often? _____
Have you ever had a problem with illicit drug use? ☐ Yes ☐ No

Exercise:
☐ Yes: How often? _____ ☐ No

Contacts:

Pharmacy:
Retail:_____ Address/Phone:_____
Retail:_____ Address/Phone:_____
Mail order:_____ Address:_____

Names of Physicians/Other Specialists which are treating you:
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____
Name:_____ Phone:_____ Specialty:_____

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 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
- ☐ Increasing constipations
- ☐ 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 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)**:**
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitive (sun allergy)
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands/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
- ☐ Transfustion / when: _____

Allergic/Immunologic:
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name:_____ Date:_____ Physician initials:_____

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489-4471 | Fax: (518) 489-4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584-4953 | Fax: (518) 584-7916

Queensbury:
17 Main Street | Queensbury, NY 12804
Phone: (518) 584-4953 | Fax: (518) 584-7916

Glenville:
115 Saratoga Rd, # 230 | Glenville, NY 12302
Phone: (518) 344-6369 | Fax: (518) 557-2653

The Center for
RHEUMATOLOGY LLP

PATIENT FINANCIAL RESPONSIBILITY FORM

I hereby authorize direct payment of medical benefits to The Center for Rheumatology, LLP for services rendered. I consent to the use or disclosure of my protected health information by The Center for Rheumatology, LLP and if needed information from other providers, for the purpose of obtaining payment for my health care bills or to conduct the healthcare operations.

I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by my contract with my insurance plan. I understand that I am financially responsible for making payment for any balance not covered by my insurance at time of service or upon receipt of a billing statement from The Center for Rheumatology. Failure to pay for the services will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency). If your statement balance is paid by check and the check is returned unpaid by your bank for any reason, a $25.00 returned check fee will be added to your account.

All copays are due at time of visit. Any outstanding balances that haven't been collected will also be due at time of visit. In some circumstances, you may be responsible for paying your deductible or coinsurance upfront for certain treatments and procedures. For these treatments, we would contact your insurance company prior to your visit to verify your benefits and to determine what amount your insurance does not pay for, and we will attempt to collect that amount at the time of your visit or prior to your appointment. It is also the patient's responsibility to obtain the necessary referral prior to their appointments if their insurance requires it. If you do not get the proper referral you would be subject for the cost of the visit if your insurance denies your claim. If you have no insurance then you would be required to pay for the cost of the office visit before being seen.

CANCELLATION POLICY

If you are unable to make your appointment, you must notify our office one day (24 hours) prior to the appointment or you will be charged a no show fee. If you miss an appointment, you will be charged $50.00. The $50.00 fee must be paid prior to being scheduled for another appointment. If you miss a new patient appointment twice, you will not be rescheduled.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form.

Printed name of patient:_____

Patient Signature:_____ Date:_____

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489-4471 | Fax: (518) 489-4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584-4953 | Fax: (518) 584-7916

Queensbury:
17 Main Street | Queensbury, NY 12804
Phone: (518) 584-4953 | Fax: (518) 584-7916

Glenville:
115 Saratoga Rd, # 230 | Glenville, NY 12302
Phone: (518) 344-6369 | Fax: (518) 557-2653

The Center for
RHEUMATOLOGY LLP

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name:_____ D.O.B._____

By signing this authorization, I authorize The Center for Rheumatology, LLP to use and/or disclose certain protected health information (PHI) about me to:

1. Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information. →

Person or Entity to Receive the Information:

_____

_____

_____

2. Please initial:

_____ I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV–RELATED INFORMATION unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

I understand that The Center for Rheumatology, LLP will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from The Center for Rheumatology, LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Printed Name of Patient or Legal Guardian:_____

Signature of Patient or Legal Guardian:_____

Relationship to Patient:_____ Date:_____

Albany:
4 Tower Place, 8th Floor | Albany, NY 12203
Phone: (518) 489–4471 | Fax: (518) 489–4506

Saratoga:
6 Care Lane, Suite 101 | Saratoga, NY 12866
Phone: (518) 584–4953 | Fax: (518) 584–7916

Queensbury:
17 Main Street | Queensbury, NY 12804
Phone: (518) 584–4953 | Fax: (518) 584–7916

Glenville:
115 Saratoga Rd, # 230 | Glenville, NY 12302
Phone: (518) 344–6369 | Fax: (518) 557–2653