RAVENSWOOD RHEUMATOLOGY

New Patient Intake Form

Personal Information

Name:	Last	First			Middle initial	Sex
Date of birth (M/D/Y): / /		Last 4 of social security number: ___ ___ ___ ___				
Address:	Street		Apt/Unit #	City	State	Zip
Preferred Phone:		Secondary phone (optional)		Email:		
Emergency Contact:	Name	Relationship		Phone number		

Preferred Pharmacy: _____ Phone:_____
Address or intersection: _____

Gender identity/preferred pronouns:
- ☐ Male, he/him
- ☐ Female, she/her
- ☐ Non-binary or other Pronouns: _____
- ☐ Prefer not to answer

Race:
- ◯ American Indian /Alaskan Native
- ◯ Black or African American
- ◯ Caucasian
- ◯ Pacific Islander
- ◯ Asian
- ◯ Middle Eastern/North African
- ◯ Multiracial
- ◯ Other _____
- ◯ Prefer not to answer

Ethnicity:
- ◯ Hispanic /Latino
- ◯ Not Hispanic/Latino
- ◯ Prefer not to answer

Primary Language:
- ◯ English
- ◯ Spanish
- ◯ Other _____

What is your employment status?
- ◯ Full time
- ◯ Part time
- ◯ Retired
- ◯ Disability
- ◯ Unemployed
- ◯ Student
- ◯ Other

If you are on disability, is it due to the condition you are seeking care for today? ☐ Yes ☐ No ☐ N/A

What is your highest level of education?
- ◯ Grade school
- ◯ Junior high (6-8)
- ◯ High school
- ◯ College
- ◯ Graduate school
- ◯ No formal education
- ◯ Prefer not to answer

Medical History

Primary Care Provider:_____ Phone:_____
Address/Health System:_____

Please tell us briefly why you are seeing a Rheumatologist today:

_____
_____
_____

What is the most limiting thing about your current symptoms:

_____

Please list any allergies, including the reaction you have:

Allergen	Reaction

In order to provide you safe care, please list your medications and supplements including name, dosage and frequency. If you have brought all your medications with you or have a written list of the names, dosage and frequency, you may skip this step

Medication	Dose	Frequency

Do you smoke cigarettes?

◯ Yes: _____ packs/day ◯ No ◯ Prior: Quit year _____

Approximately how many alcoholic drinks do you have in a week? _____

Please list any other illicit substances you use and how often: _____

_____
_____

How many days do you exercise in a typical week?

◯ 0 ◯ 1-3 ◯ 4-6 ◯ 7

How many hours of sleep do you usually get each night?

◯ 4 or less ◯ 5-8 ◯ More than 8

Please select any of the following symptoms you have experienced in the past 6 months:

- ☐ Unintentional weight gain or loss of over 10lbs
- ☐ Recurrent fevers
- ☐ Fatigue
- ☐ Night sweats
- ☐ Headaches
- ☐ Dizziness
- ☐ Brain fog
- ☐ Fainting
- ☐ Numbness/tingling
- ☐ Muscle weakness
- ☐ Significant change in vision
- ☐ Hearing loss
- ☐ Dry eyes/mouth
- ☐ Color changes in fingers/toes
- ☐ Nasal/sinus congestion or pain
- ☐ Sores in your mouth or nose
- ☐ Swollen glands
- ☐ Depression/anxiety
- ☐ Hallucinations
- ☐ Suicidal thoughts
- ☐ Chest pain
- ☐ Irregular heart beat/skipped beats
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Swelling in legs/feet
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Black or bloody stool
- ☐ Acid reflux
- ☐ Persistent diarrhea
- ☐ Ulcers in the groin or genitals
- ☐ Rashes
- ☐ Tightness/thickening of skin
- ☐ Hair loss
- ☐ Stiffness in joints for over 30minutes
- ☐ Joint pain
- ☐ Joint swelling

Have you ever been diagnosed with any of the following rheumatologic conditions?

- ☐ Ankylosing Spondylitis
- ☐ Childhood arthritis/JIA
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis (RA)
- ☐ Lupus (SLE)
- ☐ Gout
- ☐ Scleroderma
- ☐ Vasculitis
- ☐ Myositis
- ☐ Polymyalgia Rheumatica (PMR)
- ☐ Osteoarthritis
- ☐ Rheumatic fever
- ☐ Reactive arthritis
- ☐ None of these
- ☐ Other _____

Please select any other medical problems that you have been diagnosed with, if you have an unlisted medical diagnosis for which you take medication or follow with a medical provider, please write it under the "other" option:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Blood clots
- ☐ Cancer (including leukemia or lymphoma)
- ☐ Cirrhosis (liver)
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches (severe and frequent)
- ☐ Heart attack
- ☐ Heart failure
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ HIV
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Substance use disorder
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Ulcerative colitis
- ☐ No other medical conditions
- ☐ Other_____
  _____
  _____

Has anyone in your family (blood relative) been diagnosed with any of the following conditions?

- ☐ Ankylosing spondylitis
- ☐ Cancer
- ☐ Childhood arthritis
- ☐ Crohn's disease or Ulcerative Colitis
- ☐ Heart attack or stroke before age 50
- ☐ Gout
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psoriasis or Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Thyroid disease
- ☐ None of the above

Please select any of the below rheumatologic medications you have tried in the past. If you have never been on any, select "none of these"

- ☐ Steroids (ie: prednisone)
- ☐ Hydroxychloro-quine
- ☐ Methotrexate
- ☐ Leflunomide (Arava)
- ☐ Sulfasalazine
- ☐ Mycophenolate
- ☐ Azathioprine (Imuran)
- ☐ Cytoxan
- ☐ Otezla
- ☐ Humira or adalimumab biosimilar
- ☐ Enbrel
- ☐ Cimzia
- ☐ Simponi/Aria
- ☐ Remicade or infliximab biosimilar
- ☐ Stelara
- ☐ Orencia
- ☐ Benlysta
- ☐ Saphnelo
- ☐ Lupkynis
- ☐ Taltz
- ☐ Cosentyx
- ☐ Skyrizi
- ☐ Tremfya
- ☐ Actemra
- ☐ Kevzara
- ☐ Rinvoq
- ☐ Xeljanz
- ☐ Olumiant
- ☐ Rituximab
- ☐ Allopurinol
- ☐ Uloric (febuxostat)
- ☐ Probenecid
- ☐ Krystexxa
- ☐ Colchicine
- ☐ None of these

If you selected any of the above medications, roughly when did you take them and were any of them effective in treating your disease?

Medication	When did you take it? (estimate)	Effective? Y/N

If you selected any of the above medications, you have any bad reactions to any of them? Which ones and what was your reaction?

Medication	Reaction

Signatures

I attest that the above information is accurate to the best of my knowledge. I authorize the release of any medical information necessary to process claims for medical services and/or to substantiate requested services by Ravenswood Rheumatology. I hereby accept responsibility for payment of all services rendered by Ravenswood Rheumatology. Should any amount owed by me be placed with a third party for collection or litigation, I hereby agree to pay any collection fees, attorney fees, court expenses and any other relevant expensive incurred in resolving my outstanding balance.

Signature_____ Date _____

I agree to abide by the policies of Ravenswood Rheumatology. These are posted in the office, can be found online at ravenswoodmd.org and/or a copy is available through the front desk upon request. I understand that these policies are created to facilitate safe and effective medical care as well as a therapeutic relationship with providers and clinic staff. Failure to abide by these policies will limit my care and may result in my termination as a patient.

Signature_____ Date _____

I agree to receive text messages from Ravenswood Rheumatology regarding appointment confirmations/ reminders, updates on my care and updates on any major practice changes. These will not include marketing messages. I understand that I can opt out of these at any time by responding "STOP" to these messages but that opting out will prevent future appointment reminder messages from being sent.

Signature_____ Date _____

Some of our providers utilize remote or technology-assisted medical scribe services to assist with record keeping while maximizing the amount of time spent listening to patients and managing care. These scribe services are solely for the purpose of accurate record-keeping and do not participate in medical decisions, treatment or diagnosis. All information recorded is managed in compliance with HIPAA guidelines and is reviewed by your provider for accuracy. By signing below you consent acknowledge that you have read and understood this information and consent to use of these services.

Signature_____ Date _____