

**PATIENT
REGISTRATION**

Please Print Clearly

THE CENTER FOR RHEUMATOLOGY AND BONE RESEARCH
2730 UNIVERSITY BOULEVARD WEST, SUITE 306
WHEATON, MARYLAND 20902
301-942-6610

HERBERT S.B. BARAF, M.D.
ROBERT L. ROSENBERG, M.D.
EVAN L. SIEGEL, M.D.
EMMA DI IORIO, M.D.
ALAN K. MATSUMOTO, M.D.
PAUL J. DeMARCO, M.D.
ASHLEY D. BEALL, M.D.
GUADA R. RESPICIO, M.D.

PATIENT NAME LAST FIRST MIDDLE		HOME PHONE		CELL PHONE	
HOME ADDRESS			APT NO.	CITY	STATE ZIP
PATIENT STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER :			<input type="checkbox"/> EMPLOYED <input type="checkbox"/> FT STUDENT <input type="checkbox"/> PT STUDENT		
EMPLOYER			ADDRESS		WORK PHONE
PATIENT'S OCCUPATION (INDICATE IF STUDENT)			SOCIAL SECURITY NO.		DATE OF BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F
FINANCIALLY RESPONSIBLE PARTY <input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER:		RESPONSIBLE PARTY'S NAME		WORK PHONE	
RESPONSIBLE PARTY'S ADDRESS				HOME PHONE	
DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"?		MAY WE KEEP A COPY ON FILE?			
REFERRED BY		ADDRESS		PHONE	
IN CASE OF EMERGENCY, PLEASE NOTIFY:				Relationship _____	
Name _____		First _____ Middle _____ Last _____		Home Phone () _____	
Address _____				Work Phone () _____	

INSURANCE INFORMATION

Do you have health insurance? yes no (If yes, please complete the following information)

PRIMARY INSURANCE COMPANY		POLICY/ID NO.	GRP. NO/SERV. CODE
PRIMARY INSURANCE COMPANY ADDRESS			
Street	Suite #	City	State Zip Phone () _____
Name of Policyholder _____		<input type="checkbox"/> Male <input type="checkbox"/> Female Relationship _____	
POLICYHOLDER'S DATE OF BIRTH		POLICYHOLDER'S ADDRESS	
POLICYHOLDER'S EMPLOYER OR SCHOOL NAME		POLICYHOLDER'S WORK PHONE	
SECONDARY INSURANCE COMPANY		POLICY/ID NO.	GRP. NO/SERV. CODE
SECONDARY INSURANCE COMPANY ADDRESS			
Street	Suite #	City	State Zip Phone () _____
Name of Policyholder _____		<input type="checkbox"/> Male <input type="checkbox"/> Female Relationship _____	
POLICYHOLDER'S DATE OF BIRTH		POLICYHOLDER'S ADDRESS	
POLICYHOLDER'S EMPLOYER OR SCHOOL NAME		POLICYHOLDER'S WORK PHONE	

I Certify that the information I have reported is correct.

Patient Signature _____ Date _____

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"/>

Drug allergies: No Yes To what? _____

Type of reaction: _____

PAST MEDICAL HISTORY

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cancer _____ type | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Angina | <input type="checkbox"/> Lung Problems _____ type | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Other significant illnesses (please list) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | _____ |

SURGERIES:

- Total knee replacement
- Total hip replacement
- Back Surgery
- Hysterectomy
- Prostate

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____ Sisters _____ Brothers _____
 Number of children _____ Number living _____ Number deceased _____ List ages of each _____
 Daughters _____ Sons _____ Adopted _____

Do you know of 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 | |

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

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

SOCIAL HISTORY

Primary language spoken: _____ Hand Dominance _____ Right _____ Left

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 _____
Employer: _____ Retired _____ Date _____
Military Service: _____yes _____No Current status: _____

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

Do you smoke? Yes No Past – How long ago? _____ Packs a day _____ Number of years _____
Do you drink alcohol? Yes No Number per week _____ Has anyone ever told you to cut down on your drinking? _____
Do you drink caffeinated beverages? Yes No Type of Beverage _____ Cups/Glasses per day? _____
Do you use drugs for reasons that are not medical? Yes No
If yes, please list: _____

Activity Level: Sedentary _____ Moderate _____ Vigorous _____
Type of Exercise: Aerobic _____ Golf _____ Jogging _____ Skiing _____ Swimming _____ Walking _____ Yoga _____ Other _____
Exercise Frequency: _____ Times/week _____

House Pets: Yes No Type: _____

Recent Travel: Out of State _____ International _____

DIAGNOSTIC TESTS

MRI Scan _____ CT Scan _____ Biopsy _____
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 ____/____/____

SYSTEMS REVIEW

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

Constitutional

Fatigue Fever Malaise Night sweats Weakness
 Recent weight gain amount _____ Recent weight loss amount _____

HEENT

Double or blurred vision Eye dryness Feels like something in eye Itching eyes Pain
 Redness Loss of vision

Ears-Nose-Mouth-Throat

Loss of hearing Ringing in ears Loss of smell Nosebleeds Runny nose
 Sores in mouth Difficulty swallowing Hoarseness Sore tongue Frequent sore throat
 Dryness of mouth

RESPIRATORY

Shortness of breath Chest pain Cough Coughing of blood Wheezing (asthma)

CARDIOVASCULAR

Pain in chest Difficulty in breathing at night Swollen legs or feet Irregular heart beat High blood pressure

VASCULAR

Cool extremity Ulcer Raynaud's Varicose Veins Thrombosis phlebitis

GASTROINTESTINAL

Abdominal pain Black stools Blood in stools Increasing constipation Persistent diarrhea
 Difficulty swallowing Jaundice Vomiting of blood or coffee ground material Loss of bowel control
 Stomach pain relieved by food or milk Heartburn

GENITOURINARY

- Cloudy, "smoky" urine Difficulty urinating Blood in urine Getting up at night to pass urine Kidney failure

REPRODUCTIVE

- Discharge from penis/vagina Prostate trouble Vaginal Dryness Sexual Difficulties

ENDOCRINE

- Excessive thirst Abnormal sleep Goiter Increase in hat size Tremors

NEUROLOGICAL SYSTEM

- Gait disturbance Headaches Dizziness Fainting Memory loss Vertigo
 Sensitivity or pain of hands and/or feet Loss of consciousness

PSYCHIATRIC

- Depression Agitation

INTERGUMENTARY SKIN

- Sun sensitive (sun allergy) Hair loss Rash Hives Nodules/bumps Tightness

MUSCULOSKELETAL

- Back pain Joint pain Morning stiffness Joint swelling Muscle tenderness Muscle Weakness Neck pain
Lasting how long?
_____ Minutes _____ Hours

HEMATOLOGIC/LYMPHATIC

- Eye bruising Bleeding gums Swollen glands Anemia

ALLERGIC/IMMUNOLOGIC

- Asthma Hives Food allergies Environmental allergies

PRESENT PROBLEM

DIAGNOSIS: _____

Problem onset _____

Present symptoms _____

Severity 1-10 _____

Location _____

Pain quality _____

Aggravated by _____

Relieved by _____

PAST MEDICATIONS

Name of Drug Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Ansaid (flurbiprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthrotec (diclofenac + misoprostil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin (including coated aspirin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Celebrex (celecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinoril (sulindac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daypro (oxaprozin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disalcid (salsalate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dolobid (diflunisal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feldene (piroxicam)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PAST MEDICATIONS (Con't.)

Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Indocin (indomethacin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lodine (etodolac)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meclomen (meclofenamate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Motrin/Rufen (ibuprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nalfon (fenoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Naprosyn (naproxen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oruvail (ketoprofen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tolectin (tolmetin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trilisate (choline magnesium trisalicylate)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vioxx (rofecoxib)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Voltaren (diclofenac)		<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"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Relievers	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxycodone, Percocet, Oxycontin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<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"/>	
Disease Modifying Antirheumatic Drugs (DMARDS)	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Gold Salts/pills (Myochrysin or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquinil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune, Neoral or Gengraf)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adalimumab (Humira)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rituximab (Rituxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abatacept (Orencia)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Leflunimide (Arava)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Past Medications (Con't.)

Osteoporosis Medications	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not at all	
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flouride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitronin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Residronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Boniva		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gout Medications	Length of time	Please check: Helped?			Reactions
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<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"/>	
Other Medications	Length of time	Please check: Helped?			Reactions
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<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: _____
