ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Osteoporosis Assessment Center • Arthritis and Rehabilitation Therapy Services
The Center for Rheumatology and Bone Research • Arise Infusion Therapy Services
Divisions of Arthritis and Rheumatism Associates, P.C.

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Dear New Patient:

Welcome to our office. We are looking forward to meeting you at your scheduled Clinical Research appointment. Your appointment can typically be three hours or longer, please plan accordingly.

Enclosed, you will find forms related to your medical history, please complete the forms in advance and bring them with you to your initial visit. Be sure to complete the list of all medications. Accurate completion of these forms will save time when you arrive and enable you to be seen more promptly.

If you have any questions prior to your visit, please feel free to contact us. We look forward to a meaningful patient-physician-staff relationship.

Sincerely,
The Center For Rheumatology and Bone Research

2730 University Boulevard West, Suite 306, Wheaton, MD 20902 PHONE 301.942.6610 FAX 301.942.7833
www.washingtonbone.com

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Phone: 301-942-6610

Patient Registration

PATIENT NAME LAST	FIRST	M	DATE OF BIRTH	BIRTH SEX ☐ M ☐ F

HOME ADDRESS	APT NO.	CITY	STATE	ZIP

EMAIL ADDRESS:

HOME PHONE	CELL PHONE	PATIENT STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER :

PREFERRED PRONOUNS

☐ HE, HIM, HIS ☐ SHE, HER, HERS ☐ THEY, THEM, THEIRS ☐ ZE, HIR ☐ DECLINED ☐ OTHER

GENDER IDENTITY

☐ M ☐ F ☐ MALE-TO-FEMALE ☐ FEMALE-TO-MALE ☐ GENDERQUEER ☐ DECLINED ☐ OTHER

SEXUAL ORIENTATION

☐ HETEROSEXUAL/STRAIGHT ☐ BISEXUAL ☐ HOMOSEXUAL/LESBIAN/GAY ☐ DECLINED ☐ OTHER

RACE_____ ETHNICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO

PREFFERED LANGUAGE_____

FINANCIALLY RESPONSIBLE PARTY ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER:	RESPONSIBLE PARTY'S NAME	CELL PHONE

RESPONSIBLE PARTY'S ADDRESS	HOME PHONE

DO YOU HAVE AN "ADVANCE MEDICAL DIRECTIVE"?	MAY WE KEEP A COPYON FILE?

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name_____
First Middle Last

Address _____

Relationship_____

Home Phone _____

Work Phone _____

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Patient History Form

Date of first appointment:_____/_____/_____ Age: _____ Birth Sex: ☐F ☐M Birthplace: _____
mm dd yyyy

Name: _____ Birthdate: _____/_____/_____
LAST FIRST MIDDLE MAIDEN mm dd yyyy

Referred by: (check one) ____Self ____Family ____Friend ____Physician ____Other Health Professional

Name of Person Making Referral: _____

Name of Primary Care Physician:_____

PRESENT PROBLEM **DIAGNOSIS:** _____

Problem onset_____

Present symptoms _____

Severity 1-10 _____

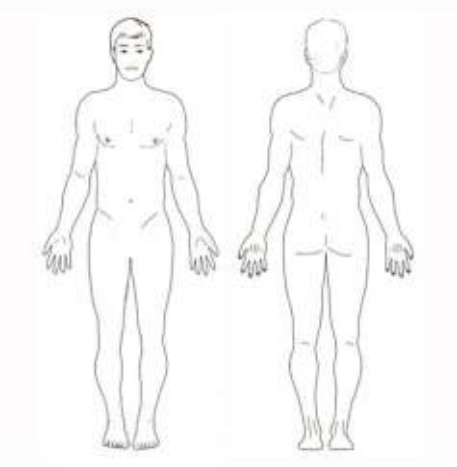
Location _____

Pain quality_____

Aggravated by _____

Relieved by _____

Please shade all the locations of your pain **over the past week** on the **body figures**



Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

For practice use only: MRN: _____ DOS: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

Name of Drug	Dose	Number of pills and how often?	How long have you taken this medication?	Please check: Helped? A Lot	Some	Not at all
1.				☐	☐	☐
2.				☐	☐	☐
3.				☐	☐	☐
4.				☐	☐	☐
5.				☐	☐	☐
6.				☐	☐	☐
7.				☐	☐	☐
8.				☐	☐	☐
9.				☐	☐	☐
10.				☐	☐	☐

PAST MEDICAL HISTORY

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

☐ Cancer type_____
☐ Goiter
☐ Depression/Anxiety
☐ Nervous Breakdown
☐ High Blood Pressure
☐ Stroke
☐ Asthma
☐ Leukemia
☐ Rheumatic Fever
☐ Bleeding Tendency
☐ Alcoholism
☐ Epilepsy
☐ Heart attack
☐ Angina
☐ Heart Failure
☐ Diabetes
☐ Stomach Ulcers
☐ Liver Problems
☐ Kidney Problems
☐ Osteoarthritis
☐ Gout
☐ Childhood Arthritis
☐ Psoriatic Arthritis
☐ Osteoporosis
☐ Thyroid Problems
☐ Lung Problems _____type
☐ Anemia
☐ Cholesterol
☐ HIV/AIDS
☐ Glaucoma
☐ Hepatitis
☐ Ankylosing Spondylitis
☐ Scleroderma
☐ Lupus or "SLE"
☐ Rheumatoid Arthritis
☐ Arthritis (unknown type)
☐ Colitis
☐ Psoriasis
☐ Tuberculosis
☐ Other significant illnesses (please list)
_____
_____

SURGERIES:

☐ Total knee replacement
☐ Total hip replacement
☐ Back Surgery
☐ Hysterectomy
☐ Prostate
☐ Other _____

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 _____

At any time has a blood relative had any of the following? (give relationship)

	Relative Relationship		Relative Relationship
Arthritis (unknown type)		Cancer	
Osteoarthritis		Leukemia	
Gout		Stroke	
Childhood arthritis		Colitis	
Lupus or "SLE"		Heart Disease	
Rheumatoid Arthritis		High Blood Pressure	
Ankylosing Spondylitis		Bleeding Tendency	
Osteoporosis		Alcoholism	
Psoriatic Arthritis		Asthma	
Scleroderma		Epilepsy	
Rheumatic Fever		Diabetes	
		Goiter	
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

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 ____/____/

REVIEW OF SYSTEMS

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

Constitutional

☐ Fatigue ☐ Fever ☐ Malaise ☐ Night sweats
☐ Recent weight gain (amount) ☐ Recent weight loss (amount)

HEENT

☐ Eye dryness ☐ Eye pain ☐ Difficulty swallowing ☐ Nose bleeds
☐ Redness of eyes ☐ VisualcChanges ☐ Dry mouth ☐ Hoarseness
Ears-Nose-Mouth-Throat ☐ Sores in mouth ☐ Loss of smell ☐ Loss of hearing

RESPIRATORY

☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Wheezing (asthma)

CARDIOVASCULAR

☐ Difficulty breathing at night ☐ Chest pain ☐ Swollen legs or feet ☐ Irregular heart beat

VASCULAR

☐ Cool extremity ☐ Ulcer ☐ Raynaud's ☐ Thrombosis phlebitis

GASTROINTESTINAL

☐ Abdominal pain ☐ Jaundice ☐ Diarrhea
☐ Heartburn ☐ Vomiting ☐ Increasing constipation
☐ Nausea ☐ Blood in stools ☐ Changes in stools

GENITOURINARY

☐ Difficulty urinating ☐ Blood in urine ☐ Increased urinary frequency ☐ Urinary incontinence

REPRODUCTIVE

Female

☐ Vaginal discharge ☐ Breast discharge ☐ Vaginal dryness ☐ Sexual dysfunctions
☐ Irregular menses

Male

☐ Penile discharge ☐ Sexual dysfunctions

ENDOCRINE

☐ Excessive thirst (Polydipsia) ☐ Abnormal sleep ☐ Goiter ☐ Tremors
☐ Hair changes

NEUROLOGICAL SYSTEM

☐ Gait disturbance ☐ Headaches ☐ Dizziness ☐ Memory loss
☐ Extremity numbness ☐ Seizures ☐ Vertigo

PSYCHIATRIC

☐ Depression ☐ Anxiety ☐ Insomnia

INTERGUMENTARY SKIN

☐ Sun sensitive (sun allergy) ☐ Hair loss ☐ Rash ☐ Hives
☐ Skin thickening

MUSCULOSKELETAL

☐ Back pain ☐ Joint pain ☐ Morning stiffness ☐ Joint swelling
☐ Muscle weakness ☐ Neck pain ☐ Muscle tenderness
Lasting how long:_____Minutes _____Hours

HEMATOLOGIC/LYMPHATIC

☐ Easy bruising ☐ Easy Bleeding ☐ Swollen Glands ☐ Anemia

ALLERGIC/IMMUNOLOGIC

☐ Asthma ☐ Seasonal allergies ☐ Food allergies ☐ Environmental allergies

PAST MEDICATIONS

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

Non-Steroidal/Anti-Inflammatory Drugs (NSAIDs)	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Indocin (indomethacin)		☐	☐	☐	
Lodine (etodolac)		☐	☐	☐	
Meclomen (meclofenamate)		☐	☐	☐	
Motrin/Rufen (ibuprofen)		☐	☐	☐	
Nalfon (fenoprofen)		☐	☐	☐	
Naprosyn (naproxen)		☐	☐	☐	
Oruvail (ketoprofen)		☐	☐	☐	
Tolectin (tolmetin)		☐	☐	☐	
Trilisate (choline magnesium trisalicylate)		☐	☐	☐	
Vioxx (rofecoxib)		☐	☐	☐	
Voltaren (diclofenac)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Pain Relievers Acetaminophen (Tylenol)	Length of time	Please check: Helped? A Lot ☐	Some ☐	Not at all ☐	Reactions
Oxycodone, Percocet, Oxycontin		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)	Length of time	Please check: Helped? A Lot	Some	Not at all	Reactions
Gold Salts/pills (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquinil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	

Sulfasalazine (Azulfidine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune, Neoral or Gengraf)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Adalimumab (Humira)		☐	☐	☐	
Rituximab (Rituxan)		☐	☐	☐	
Abatacept (Orencia)		☐	☐	☐	
Leflunimde (Arava)		☐	☐	☐	
Other:		☐	☐	☐	

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

Please list supplements: _____

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No If yes, list: _____

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AUTHORIZATION TO RELEASE INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your physician or his/her staff to discuss your medical and/or financial information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I DO authorize the Practice to release any or all information to the following individuals:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Patient Signature	_____ Date

Revised 5/2021

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ARA PATIENT CODE OF CONDUCT

Cell Phones/Electronic Devices: Cell phones and electronic devices are permitted in the office but must be turned to silent or vibrate. Phone conversations, video chat, and live-stream are prohibited while in the office. Headphones must be worn while using a cell phone or electronic device for listening to music, watching videos, etc.

Photographs/Recording: Photos, Audio and Video recording, using any electronic device, is strictly prohibited.

Masks: Masks are required to be worn over the nose and mouth by all patients and visitors while in the office. Mask may be medical grade or cloth. Mask removal is permitted only for taking oral medications, eating, and drinking. Masks must be promptly replaced after eating and drinking.

Children under 18 years: All children under 18 years old must be accompanied by an adult. Children may not be left alone without adult supervision in any area of the office and are not allowed in treatment areas, including but not limited to, the infusion, physical therapy, radiology departments. Patients under 18 years old must be accompanied by an adult.

Privacy: We ask that you respect the privacy of other patients. All patients must remain in designated patient areas (waiting room, exams rooms, and other testing/treatment areas). Patients may not enter any area designated for staff only.

Safety: The staff takes every precaution to ensure a safe and pleasant visit. Safety is our highest priority. If you have any safety concerns, please bring it to the attention to a staff member or a manager immediately.

Respect: We ask that you respect the staff and other patients in the office. Any threatening or derogatory language, racial slurs, cursing, etc., will not be tolerated. Anyone who engages in this behavior will be asked to leave immediately and may be discharged from the practice.

No Show / Same Day Cancellation Fee: A Fee will be assessed for all no shows or same day cancellations. We request that cancellations or scheduling changes be made during clinic hours no later than the last business day prior to your appointment.

I, _____ , certify that I have read and understand the code of conduct and will comply with all ARA /ARISE protocols. I acknowledge that failure to do so may result in being discharged from ARA and all its services.

Signature: _____ Date: _____