Angela M. Stupi, M.D.

Rachel Pastorek, PA-C

Nicole Haas, PA-C

Caroline O'Neil, PA-C

Advanced Rheumatology & Arthritis Wellness Center

144 Emeryville Drive
Suite 220
Cranberry Township, PA
16066
724-935-9355
724-935-9360 (FAX)

NEW PATIENT HISTORY

In order to give you the best care possible, please complete this form and bring it to your appointment of the day of your first visit. The information on this form will remain confidential and will become part of your medical record.

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____

Date of Appointment:_____ Referring Physician:_____

Primary Care Physician:_____

Date of Birth:_____ Age:_____ Gender: ◯ Male ◯ Female

Phone Number:_____ (Home) Phone Number:_____ (Cell)

Email Address:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

Race: Please describe your race ◯ White or Caucasian ◯ Black or African American
◯ Asian ◯ American Indian or Alaska Native ◯ Indian ◯ Middle Eastern
◯ Native Hawaiian or Pacific Islander ◯ Other, please specify: _____
Please describe the race of your mother:_____ father:_____

WHAT IS THE NATURE OF YOUR VISIT TODAY?_____
_____

MEDICAL HISTORY: Please list any of your medical problems, past and present and date of onset:

Medical Problem, Hospitalization or Surgery	Date of Onset	Is this still a current issue?

PATIENT NAME:_____ DOB:_____

FAMILY HISTORY: Please list family member or blood relatives known to have the following diagnoses and indicate their relationship to you as well as the MATERNAL (M) or PATERNAL (P) side of your family

CURRENT MEDICATIONS: Please list your current medication. Include over the counter medicines, birth control, vitamins, herbal supplements etc.

Diagnosis	**Family Member**	**Diagnosis**	**Family Member**
LUPUS (SLE)		SCLERODERMA	
POLYMYOSITIS		VASCULITIS	
RHEUMATOID ARTHRITIS		RAYNAUD'S	
SJOGRENS		OSTEOARTHRITIS	
OSTEOPOROSIS		FIBROMYALGIA	
ANKYLOSING SPONDYLITIS		PSORIASIS	
THYROID DISEASE		SYSTEMIC SCLEROSIS	
MIXED CONNECTIVE TISSUE DIS-		MYASTHENIA GRAVIS	
PERNICIOUS ANEMIA		HEMOLYTIC ANEMIA/ITP	
TYPE 1 DIABETES (INSULIN-		MUSCLE DISEASE (PLEASE SPECIFY)	
CANCER, (PLEASE SPECIFY)		HYPERTENSION	
HEART DISEASE		KIDNEY STONE(S)	
CROHN'S DISEASE		ULCERATIVE COLITIS	
MULTIPLE SCLEROSIS		GOUT	

Medication Name	**Dosage (mg)**	**How Often taken**	**Diagnosis**	**Date Started**

MARITAL STATUS:

◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Domestic Partner

If married, spouse's name: _____

Are you living with anyone? Name: _____

Children? ◯ No ◯ Yes How many?_____ Age(s) and gender(s)_____

Education: Please indicate the highest level of education that you have received

1 2 3 4 5 6	**7 8 9**	**10 11 12**		**13 14 15 16**	**17**
Elementary	**JHS**	**HS**	**Technical/Trade**	**College**	**Grad**

Employment: Please indicate your current work status:

◯ Working Full time Part time Temporary Seasonal

◯ Retired Year:_____

◯ Homemaker

◯ Student Graduation Year:_____

◯ Disabled Date:_____

◯ Job Hunting/Unemployed

◯ Other, specify:_____

If you are currently working, what is your current occupation?_____

Have you been regularly exposed to any of the following?

◯ Noise ◯ Solvents ◯ Pesticides ◯ Mercury Lead or other metal

◯ Asbestos ◯ Radiation ◯ Gases/Dust

Exercise: Do you exercise regularly? ◯ Yes ◯ No

What type of exercise do you perform? _____

How often per week? _____

Tobacco Use: Do you currently use tobacco? ◯ Yes ◯ No If yes, how many packs per day?____

If no, have you ever smoked? ◯ Yes ◯ No If yes, when?_____ for how long?_____

Alcohol Use: Please indicate how often you drink alcoholic beverages

◯ Never

◯ Occasionally (less than 1/month)

◯ Monthly

◯ 2-4 times per month

◯ 2-4 times per week

◯ more than 4 times per week

How many alcoholic beverages do you consume weekly? _____

If you quit drinking, how long ago did you quit?_____

DEXA SCANS

Have you had any DEXA scans? ◯ Yes ◯ No Date:_____

PHYSICAN INFORMATION

Primary care Physician Name:_____Phone:_(_____)_____

Address:_____Fax:_(_____)_____

Specialist 1 Name:_____Phone:_(_____)_____

Address:_____Fax:_(_____)_____

Specialist 2 Name:_____Phone:_(_____)_____

Address:_____Fax:_(_____)_____

Specialist 3 Name:_____Phone:_(_____)_____

Address:_____Phone:_(_____)_____

INSURANCE (Primary card holder information)

Last Name_____ First Name_____

Birth Date_____ Sex ◯ Male ◯ Female

Address_____ City_____ State_____ Zip_____

Phone Number_____ Email_____

Insurance Name_____ ID #_____

Group Name_____ Group #_____

Pharmacy:_____ Phone:_____

Secondary Insurance (If any) Plan Name:_____ ID#_____

I UNDERSTAND THAT PAYMENT OF ALL MEDICAL CARE, INCLUDING CO-PAY, IS DUR AT THE TIME OF SERVICE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURANCE, AND/OR ANY OTHER BALANCE NOT PAID BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COST INCURRED IN THE COLLECTION OF PATIENTS ACCOUNT IN CASE OF DEFAULT. I HEREBY GRANT PERMISSION TO ADVANCED RHEUMATOLOGY AND ARTHRITIS WELLNESS CENTER, PC TO RELEASE ANY PERTINENT INFORMATION TO MY INSURANCE COMPANY UPON REQUEST, I ALSO AUTHORIZE PAYMENT DIRECTLY TO ADVANCED RHEUMATOLOGY AND ARTHRITIS WELLNESS CENTER, PC.

PATIENT SIGNATURE_____ DATE_____

Name of Pharmacy:_____
Address:_____
Phone:_____ **Fax:**_____

Have you ever taken the following medications? If So please indicate How long you were on that medication and the date your stopped taking it.

	How Long were you on it?	**Date Stopped**
◯ Hydroxychloroquine (Plaquenil®)	_____	_____
◯ Methotrexate (Rheumatrex®) (If you have taken multiple courses please indicate highest dose as well)	_____	_____
◯ Prednisone (If you have taken multiple courses please indicate highest dose as well)	_____	_____
◯ Sulfasalazine (Azulfidine)	_____	_____
◯ Azathioprine (Imuran)	_____	_____
◯ Mycophenolate Mofetil (CellCept®)	_____	_____
◯ Mycophenolic Acid (Myfortic®)	_____	_____
◯ Rituximab (Rituxan®)	_____	_____
◯ Etanercept (Enbrel®)	_____	_____
◯ Infliximab (Remicade®)	_____	_____
◯ Adalimumab (Humira®)	_____	_____
◯ Certolizumab (Cimzia®)	_____	_____
◯ Golimumab (Simponi®)	_____	_____
◯ Tocilizumab (Actemra®)	_____	_____
◯ Abatacept (Orencia®)	_____	_____
◯ Gold Injections	_____	_____
◯ Cyclophosphamide (Cytoxan®)	_____	_____
◯ Dapsone (DDS)	_____	_____
◯ Tacrolimus (Prograf®) ~ FK506	_____	_____
◯ Intravenous Immune Globulin (IVIG)	_____	_____
◯ Cyclosporine (Neoral®)	_____	_____
◯ Warfarin (Coumadin®)	_____	_____
◯ Birth Control Pills	_____	_____
◯ Celebrex	_____	_____
◯ Cataflam	_____	_____
◯ Voltaren	_____	_____
◯ Lodine	_____	_____
◯ Ibuprofen	_____	_____
◯ Indocin	_____	_____
◯ Oruvall	_____	_____
◯ Toradol	_____	_____
◯ Mobic	_____	_____
◯ Relafen	_____	_____
◯ Naprosyn	_____	_____
◯ Feldene	_____	_____
◯ Clinoril	_____	_____

ALLERGIES: Please list any medication or other allergies.
If you have none please check: ◯ **No Known Allergies**

ALLERGY	REACTION

CONSTITUTIONAL/DATE OF ONSET	MUSCULOSKELETAL/DATE OF ONSET
◯ Fatigue	◯ Morning Stiffness (How many hours?)_____
◯ Weight Loss (# of pounds)	◯ Joint Pain (Which joints?)_____
◯ Fever	◯ Joint Swelling (Which joints?)_____
◯ Trouble Sleeping	◯ Muscle Pain
EYES/DATE OF ONSET	◯ Muscle Weakness
◯ Dry Eyes	◯ Broken Bones
◯ Red Eyes	**NEUROLOGICAL/DATE OF ONSET**
◯ Visual Changes	◯ Seizures
EAR, NOSE, THROAT & MOUTH/DATE OF ONSET	◯ Numbness or Tingling
◯ Dry Mouth	◯ Headache
◯ Mouth Ulcers	◯ Stroke/Mini-Stroke/TIA
◯ Loss of Teeth	◯ Trigeminal Neuralgia
◯ Nasal Ulcers	◯ Carpel Tunnel Syndrome
◯ Hearing Loss	**RESPIRATORY/DATE OF ONSET**
◯ Hoarse Voice	◯ Shortness of Breath
INTEGUMENTARY (SKIN)/DATE OF ONSET	◯ Cough
◯ Sensitivity to Sun	◯ Use of Oxygen
◯ Rash	**CARDIOVASCULAR/DATE OF ONSET**
◯ Psoriasis	◯ Chest Pain
◯ Nodules	◯ Palpitations

CARDIOVASCULAR CONTINUED/DATE OF ONSET	GENITOURINARY/DATE OF ONSET
◯ Angina	◯ Pain/Burning during urination
◯ Leg Swelling	◯ Frequent Urinary Tract Infections
◯ Heart Attack	◯ Difficulty Passing Urine
◯ Congestive Heart Failure	◯ Blood in Urine
◯ Pulmonary Hypertension	**REPRODUCTIVE/DATE OF ONSET**
◯ Cardiac Catheterization	◯ **Male:** Difficulty getting or maintaining an erection
◯ Arrhythmia or Irregular Heat Rate (Are you on medication for this condition?) ◯ Yes ◯ No	◯ **Female:** Infertility ◯ Yes ◯ No Irregular Menstrual Cycle ◯ Yes ◯ No
◯ Fingers Change Color in the Cold	**ENDOCRINE/DATE OF ONSET**
◯ Blood Clots	◯ Thyroid disease
GASTROINTESTINAL/DATE OF ONSET	◯ Hot Flashes
◯ Trouble Swallowing	◯ Dry Skin
◯ Heartburn/Acid Reflux	◯ Fractures
◯ Bloating	◯ Hair Loss
◯ Abdominal Pain	**HEMATOLOGIC/LYMPHATIC/DATE OF ONSET**
◯ Frequent Diarrhea	◯ Nose Bleeds
◯ Constipation	◯ Swollen Glands
◯ Parenteral Nutrition (Tube Feedings)	◯ Bruising
ALLERGIC/IMMUNOLOGIC/DATE OF ONSET	◯ Frequent Infection
◯ Hives	**PSYCHIATRIC**
◯ Runny nose	◯ Anxiety
◯ Itching of the Eyes	◯ Depression
OTHER	

***FEMALES ONLY* OB/GYN HISTORY**

Have you ever been pregnant? ◯ Yes ◯ No Have you ever been diagnosed with pre-eclampsia? ◯ Yes ◯ No

Pregnancies: # Full term babies, greater than 5.5 lbs _____ # Full term babies, less than 5.5 lbs _____

Premature babies (< 38 weeks) : _____ # Miscarriages: _____ # Stillbirths (>20 weeks):_ _____

Ectopic Pregnancies: _____ # Abortions: _____

Have you gone through menopause? ◯ Yes ◯ No Natural? Surgical? Drug-induced? If yes, age: _____

VACCINATIONS (MOST RECENT)

Influenza (Flu) ◯ Yes ◯ No ◯ Don't know Date _____ Skin test for TB ◯ Yes ◯ No ◯ Don't know Date_____

Pneumonia (Pneumovax) ◯ Yes ◯ No ◯ Don't know Date_____

Hepatitis A ◯ Yes ◯ No ◯ Don't know Date_____ Hepatitis B ◯ Yes ◯ No ◯ Don't know Date_____

PATIENT CONFIDENTIALITY FORM

PATIENT NAME:_____**DOB**:_____

Patient confidentiality is our top priority at Advanced Rheumatology and Arthritis Wellness Center. Therefore it is important that you provide us with the following information so we may ensure there is no violation with your privacy.

Advanced Rheumatology and Arthritis Wellness Center may leave detailed messages regarding your radiology testing, lab results, scheduled appointments, procedures and billing information with the following:

Name	Relation	Phone Number

Please list the family members or other persons, if any, whom are authorized to pick up health care information such as medical records, prescriptions, supplies, test results, etc. in person on your behalf:

Name	Relation	Phone Number

If you are the representative speaking on behalf of the patient, please specify relationship to the patient and authority to act:

Name:_____**Relationship to patient**:_____

This form is not intended to replace an authorization, but it allows a patient to choose an alternative method for communication regarding their health care.

Patient/Representative Signature:_____**Date**:_____