ARTHRITIS CLINIC & MED ASSOC
11937 Central Ave NE
Blaine, MN 55434

Dear Patient,

A very warm welcome to you! We thank you for selecting our office for your Rheumatology care.

Your appointment is scheduled with Dr. Shambeel Rizvi, on _______________(*date*), _____________ (*time*) at the following location :

☐ **Monticello Office**	☐ **Blaine Office**	☐ **Buffalo Office**
1001 Hart Blvd.,	11937 Central Ave NE	1700 Highway 25 N
Monticello, MN 55362	Blain, MN 55434	Buffalo, MN 55313

Enclosed you will find your new ***patient health history forms*** and a ***face- sheet***. Please complete both sides of the forms. On the ***face-sheet*** the insurance information section may be left blank as we will be taking photocopy of your insurance card on the day of your appointment.

Please note: - You must have your insurance card(s) and a photo ID to your appointment.

All co-pays are due at the time of your appointment and must be paid with cash, credit or check.

If you have any questions about these forms or your appointment please feel free to call us at
(763) 634 2273 or (763) 463 9515

Thank you

Medical Assistant to Dr. Shambeel Rizvi

Arthritis Clinic & Medical Associates P.C

PATIENT INFORMATION

Patient Name____ Date of Birth____________________

Social Security #____________________Home Phone #____________________Work Phone #______________

Address ___________________________________City _____________________ State _____ Zip___________

Employer ____Occupation ______________________

Name of Spouse_____________________Employer__________________________Work Phone #____________

INSURANCE INFORMATION

Primary Insurance____Address____

Group # __________________________ ID # ________________________________ Co-pay $ _____________

Policy Holder Name_____________Social Security ___________Date of Birth _________Relationship__________

Secondar Insurance____Address____

Group # __________________________ ID # ________________________________ Co-pay $ _____________

Policy Holder Name_____________Social Security ___________Date of Birth _________Relationship__________

ADDITIONAL INFORMATION

Emergency Contact (not living with you) _____________________________Relationship___________________

Home Phone # ____________________________ Work Phone # ________________________

Primary Physician___________________________Clinic__________________________Phone______________

Referring Physician _________________________Clinic __________________________Phone_____________

Pharmacy Name _________________________

Pharmacy Address____ City___________State___ Zip_________

By signing below I acknowledge this information is correct. I authorize my insurance company to remit payment directly to my physician for services rendered. I agree that my medical records for treatment may be released to my insurance company for claims processing. I authorize the release and disclosure of any and all of my medical records to my referring and primary care physician. Arthritis clinic & Medical Associates will share your information with a third party Billing company and will comply with HIPPA laws, to protect your privacy.

I understand that I am responsible for knowing my insurance coverage. I understand it is my responsibility to obtain any referrals required by my insurance plan. I am aware that I am responsible for any balance not paid by my insurance, and I agree to pay all statements upon receipt.

Signature ____ Date__________________

Printed Name ____________________________________Relationship to patient_______________

ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

❑ **Blaine** ❑ **Monticello** ❑ **Plymouth** ❑ _______________

RHEUMATOLOGY PATIENT HISTORY FORM

Today 's Date: _______________

NAME: ____ **DOB:** ______________

Last First M. I.

Age:___________ Sex: ❑ F ❑ M

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

Whom do we thank for referring you here? ____

Name of your primary care physician: ____

Describe briefly your present symptoms: ________

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:

Left Right Left

Left Right

Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? ________

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem: ________

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later):

Initial ________

ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

NAME: ____ **Today 's Date**: ________________

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

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	________________
Osteoarthritis	❑	❑	→	________________
Rheumatoid arthritis	❑	❑	→	________________
Gout	❑	❑	→	________________
Lupus or "SLE"	❑	❑	→	________________
Ankylosing spondylitis	❑	❑	→	________________
Childhood arthritis	❑	❑	→	________________
Sjogren's syndrome	❑	❑	→	________________
Osteoporosis	❑	❑	→	________________
Psoriasis/psoriatic arthritis	❑	❑	→	________________

PAST MEDICAL HISTORY

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

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _________________
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems

❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones

❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS
Uveitis/ Iritis

Other significant illnesses (please list): ____

____

Previous Operations

	Type	*Year*	*Reason*
1.	____________________	________	____________________
2.	____________________	________	____________________
3.	____________________	________	____________________
4.	____________________	________	____________________
5.	____________________	________	____________________

Any previous fractures? ❑ No ❑ Yes Describe ____________________________________

Any other serious injuries? ❑ No ❑ Yes Describe ____________________________________

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _________

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: __________ How much: ______________________

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: ________________

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Are you Applying for Disability? ❑ **Yes** ❑ **No**

Initial ________

ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

NAME: ____ **Today 's Date**: ____________________

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? ____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? ____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week ______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability?____

What date did this disability begin? ____________

With whom do you currently live? ____

How much exercise do you get each week? ____________________ What kind of exercise? __________________

FAMILY HISTORY

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

Number of siblings: ________ Number living _________

Number of children ________ Number living _________ List ages of each ________________________

Health of children: ____

Initial _________

ARTHRITIS CLINIC & MEDICAL ASSOCIATES P.C

NAME: ____ **Today 's Date**: _________________

SYSTEMS REVIEW

Date of last eye exam ________ Date of last chest x-ray ________

Date of last bone density test _____________

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: ___________

GENERAL
❑ Recent weight gain; how much____
❑ Recent weight loss: how much____
❑ Fatigue
❑ Weakness
❑ Fever
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Morning stiffness
Lasting how long ____ Minutes
____ Hours
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
List joints affected in the last 6 months

____
____
____
____

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Feels like something in eye

MOUTH
❑ Sore tongue
❑ Bleeding gums
❑ Sores in mouth
❑Loss of taste
❑ Dryness
❑ Recent increase in tooth cavities

NOSE
❑ Nosebleeds
❑ Loss of smell

THROAT
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Pain in jaw while chewing

NECK
❑ Swollen glands
❑ Tender glands

HEART AND LUNGS
❑ Pain in chest
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Swollen legs or feet
❑ Cough
❑ Coughing of blood
❑ Wheezing

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain relieved by food
❑ Vomiting of blood/"coffee grounds"
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

KIDNEY/URINE/BLADDER
❑ Difficult urination
❑ Pain or burning on urination
❑ Blood in urine
❑ Cloudy, "smoky" urine
❑ Pus in urine
❑ Discharge from penis/vagina
❑ Frequent urination
❑ Getting up at night to pass urine
❑ Vaginal dryness
❑ Rash/ulcers
❑ Sexual difficulties
❑ Prostate trouble

BLOOD
❑ Anemia
❑ Bleeding tendency

SKIN
❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Sun sensitive
❑ Skin tightness
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of
hands or feet in the
cold (Raynaud's)

NERVOUS SYSTEM
❑ Headaches
❑ Dizziness
❑ Fainting or loss of consciousness
❑ Numbness or tingling in hands/feet
❑ Memory loss
❑ Muscle weakness

PSYCHIATRIC
❑ Depression
❑ Excessive worries
❑ Difficulty falling asleep
❑ Difficulty staying asleep

For women only:
Age when periods began: ___________
Number of pregnancies: ____________
Number of miscarriages: ____________
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: ____________
Date of last mammogram: ___________

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _________

Signature:________________ Date:- ________