EAST ALABAMA RHEUMATOLOGY CENTER

East Alabama Health

DR. LAURA B. HUGHES

DR. THAO N. TRAN

Hello _____

Welcome to East Alabama Rheumatology Center,

Thank you for allowing our practice to serve you. As part of our efforts to save time during your first visit, we have enclosed our New Patient Intake Packet. **Please complete this packet and bring it with you to your first visit. You will also want to bring your insurance cards, (this includes medical AND pharmacy/prescription cards), and a photo ID.**

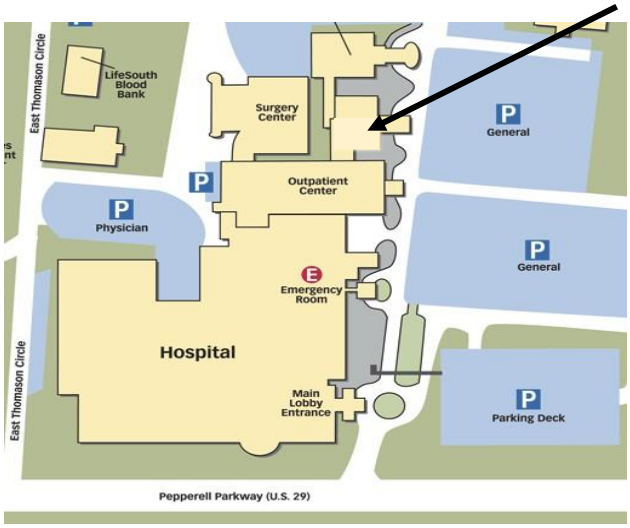
We look forward to seeing you on _____.
Please arrive 20 minutes prior to your scheduled appointment time. If you arrive 10 minutes or more after your appointment time, we reserve the right to reschedule your appointment.

If you cannot make it to your appointment, please notify us at least 24 hours before your appointment time. Please note, same day cancellations are considered the same as a no-show. If you have two no-shows, it is at the provider's discretion on whether your appointment will be rescheduled. We reserve the right to charge you for missed appointments or cancellations without notice. If you do not show or call in advance, at least 24 hours, you may be charged up to $50.00.

Thank you,

EARC Staff

East Alabama Rheumatology Center is located at **East Alabama Medical Center**, in Suite 4.



APPT: _____

RHEUMATOLOGY CENTER
East Alabama Health

DR. LAURA B. HUGHES & DR. THAO N. TRAN

NAME: _____DOB:_____GENDER:_____
PRIMARY CARE PROVIDER/CLINIC:_____
PHARMARCY and PHONE:_____
ALLERGIES: _____

Reason why you are here to see the rheumatologist? Please briefly describe your symptoms.

When did your symptoms begin?

When you wake up in the morning, are your joints stiff? [ ] Yes or [ ] No; If Yes, for how many minutes?_____

Have you seen a rheumatologist in the past? If so, who? What diagnosis was this doctor treating you for?

Please list any previous treatment you have received for this problem?

PAST MEDICAL HISTORY: Have you had any of the following illnesses? (Check please)

	Diabetes ("sugar")		Heart Failure (CHF)		Osteoarthritis
	High Blood Pressure		Thyroid Problems		Depression
	High Cholesterol		Seizures		Anxiety
	Asthma		Headaches/Migraines		Psoriasis
	COPD		Kidney Disease		Seasonal Allergies
	Stroke		Kidney Stones		Fibromyalgia
	Heart Attack		Liver Problems		Reflux (Heartburn)
	Obstructive Sleep Apnea		Cancer		Osteoporosis

Please list any other medical conditions that you are being treated for?

MEDICATIONS: Please list any medicines including supplements that you are currently taking (or bring a list with you). Please include strength and directions for taking.

Please list medications you have tried in the past for your Autoimmune Condition. Please include reason for stopping, if any.

PAST SURGICAL HISTORIES: Especially any relevant orthopedic procedures.

SOCIAL HISTORY:

Smoking Status: [ ] Former Smoker [ ] Current Smoker [ ] Never Smoked

Do you drink alcohol? If so, how often? _____

Do you currently use/have ever used any illicit drugs? _____

Do you exercise? If yes, what do you do? How often? _____

How is your sleep at night? Please circle [ ] Good [ ] Fair [ ] Poor

Do you snore? [ ] Yes [ ] No

Are you: [ ] Married [ ] Single [ ] Divorced [ ] Separated

How many people reside in the home with you? Please list them.

What are your hobbies? How do you manage stress?

Employment type - Please circle: Full time Part time Retired Disabled

If Employed, what is your occupation?

FAMILY HISTORY: Please check where appropriate.

Diseases	**Mother**	**Father**	**Siblings**	**Diseases**	**Mother**	**Father**	**Siblings**
Arthritis (type unknown)				Gout			
Osteoarthritis				Osteoporosis			
Rheumatoid Arthritis				Ankylosing Spondylitis			
Systemic Lupus				Crohn's			
Myositis				Ulcerative Colitis			
Psoriasis				Psoriatic Arthritis			
Gout				Reactive Arthritis			

Please list any other medical illnesses in your family:

REVIEW OF SYSTEMS - Please circle any symptoms that pertain to you:

Constitutional: Fever / Chills / Fatigue / Weight change / Night Sweats / Insomnia / NONE

Eyes: Dry eyes / Visual Loss / Blurred Vision / Tearing / Redness / Pain / Glasses / Contacts / NONE

ENT: Dry Mouth / Mouth Sores / No Sores / Dental Pain / Cavities / None

Cardio: Racing heart / Chest pain / Chest Pressure / History of Pericarditis / NONE

Pulm: Shortness of Breath / Wheezing / Cough / Painful Breathing / NONE

GI: Nausea / Vomiting / Diarrhea / Heartburn / Blood in Stools / Difficulty or Painful Swallowing / NONE

Skin: Rashes / Dry Skin / Hair loss / Sun Sensitivity / Discoloration of hands with cold exposures / NONE

Neuro: Numbness / Tingling / Headaches / Weakness / Carpal Tunnel / Frequent Falls / NONE

BONE HEALTH

Have you ever had a bone density exam? [ ] Yes [ ] No. If yes, when was your last exam? _____

If you are a woman, have you gone through menopause? [ ] Yes [ ] No. If yes, when? _____

Do you take Calcium supplement? [ ] Yes [ ] No. If yes, how much? _____

Do you take Vitamin D Supplementation? [ ] Yes [ ] No. If yes, how much?_____

Have you ever had a fracture or broken bone? Please list: _____

Do you have a history of cancer or radiation? [ ] Yes [ ] No. If yes, when? _____

VACCINATION

Do you get your annual flu shot? [ ] Yes [ ] No. If not, why not? _____

Have you ever received the pneumonia vaccine? [ ] Yes [ ] No. If yes, when? _____

Have you ever received the zoster / shingles vaccine? [ ] Yes [ ] No. If yes, when? _____

Have you received any other vaccines as an adult? If so, please list_____

WOMEN HEALTH

Are you (circle): Post-menopause Pre-menopause Going through menopause

Please list last menstrual period (if pre-menopause)_____ Number of pregnancies_____

Number of live births _____Miscarriages_____Abortions_____

Are you planning to get pregnant? [ ] Yes [ ] No

If applicable, are you on birth control? [ ] Yes [ ] No. If yes, what type? _____

Please indicate below if you have previously taken any of the medications below by marking the appropriate box and then why you stopped taking

Generic Name	Brand Name	Previously Used?	Reason for Stopping
Aspirin	Bayer Aspirin		
Diclofenac (pills)	Arthrotec, Cambia, Zipsor		
Diclofenac (topical)	Voltaren, Pennsaid, Flector		
Etodolac	Lodine		
Ibuprofen	Advil, Motril, Caldolor		
Indomethacin	Indocin		
Ketoprofen	Anafen		
Ketorolac	Toradol		
Meloxicam	Mobic		
Nabumetone	Relafen		
Naproxen	Aleve, Naprosyn		
Piroxicam	Feldene		
Sulindac	Clinoril		
Azathioprine	Imuran		
Methotrexate (pills)	Rheumatrex/Trexall		
Methotrexate (injection)	Rasuvo/Otrexup		
Hydroxychloroquine (HCQ)	Plaquenil		
Mycophenolate	Cellcept		
Sulfasalazine	Azulfidine		
Leflunomide	Arava		
Cyclosporin	Gengraf/Neoral/Sandimmune		
Etanercept	Enbrel		
Adalimumab	Humira		
Infliximab	Remicade/Inflectra		
Certolizumab	Cimiza		
Golimumab	Simponi/Simponi Aria		
Abatacept	Orencia		
Rituximab	Rituxan		
Tocilizumab	Actemra		
Sarilumab	Kevzara		
Tofacitinib	Xeljanz		
Baricitinib	Olumiant		
Upadacitinib	Rinvoq		
Secukinumab	Cosentyx		
Ixekizumab	Taltz		
Ustekinumab	Stelara		
Apremilast	Otezla		
Anakinra	Kineret		
Belimumab	Benlysta		

Patient Name: _____