Advanced Arthritis & Rheumatology Care

14360 Sommerville Ct.
Midlothian, VA 23113
Phone: 804-639-7850 Fax: 804-806-5988

Date: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed **Language:** _____

Sex: ○ Male ○ Female **Race:** _____ **Ethnicity:** Hispanic ____ or Non-Hispanic _____

Name: _____ **DOB:** _____
Last First MI

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ **Home Phone:** _____

Email: _____ **Cell Phone:** _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact: _____ Phone: _____

1) **Primary Insurance:** _____

Subscriber Name: _____ Subscriber's DOB: _____

Relationship to Patient: _____ Insurance ID#: _____ Group #: _____

2) **Secondary Insurance:** _____

Subscriber Name: _____ Subscribers DOB: _____

Relationship to Patient: _____ Insurance ID#: _____ Group #: _____

Primary Care Physician Name: _____ Ph: _____

Preferred Pharmacy: _____ **Address:** _____

Phone: _____

This is an Authorization for Treatment. I understand I am responsible for any amount not covered by my insurance.
I have reviewed and accepted the AARC Financial Policy.

_____ _____
Signature of Patient **Date**

NAME: DATE OF INITIAL VISIT:

1. PLEASE DESCRIBE YOUR CHIEF MEDICAL COMPLAINT BRIEFLY:

2. PAST MEDICATIONS TAKEN FOR ARTHRITIS:

Name of Medication	Dose (mg)	Taken how long?	Results

3. CURRENT MEDICATIONS FOR ARTHRITIS:

Name of Medication	Dose (mg)	Taken how long?	Results

4. OTHER REGULAR MEDICATIONS:

Name of Medication	Dose (mg)	Taken how long?	Results

5. CURRENT MEDICAL CONDITIONS AND/OR SURGERY: (Give diagnosis and dates)

6. ALLERGIES TO MEDICATIONS: (Please list)

7. FAMILY HISTORY:

Relationship:	Medical conditions or cause of death:
Father	
Mother	
Brother/Sisters	
Children (ages)	

8. SOCIAL HISTORY

A. Smoking Status

Current every day smoker	☐ No	☐ Yes	(packs per day)
Current some day smoker	☐ No	☐ Yes	(packs per day)
Former smoker	☐ No	☐ Yes	(packs per day)
Never smoked	☐		

B. Do you drink alcohol? ☐ No ☐ Yes (drinks per day)

C. Occupation? Retired? ☐ No ☐ Yes

9. VACCINE HISTORY

A: Influenza (flu) vaccine:

☐ No

☐ Yes Date received _____

B: Pneumonia vaccine

☐ No

☐ Yes Date received _____

10: DEXA SCAN AFTER THE AGE OF 60?

☐ No

☐ Yes Date of scan _____

11. REVIEW OF SYSTEMS - (Please place check mark (✓) next to all that apply):

SKIN
- ☐ psoriasis
- ☐ other rash
- ☐ rash from sun
- ☐ fingers turn white or blue in cold
- ☐ easy bruising
- ☐ abnormal loss of hair
- ☐ sores on fingertips
- ☐ tick bites

EYES
- ☐ dry eyes
- ☐ redness of eyes
- ☐ loss of vision
- ☐ eye pain or history of uveitis

EARS, NOSE & THROAT
- ☐ dry mouth
- ☐ frequent mouth ulcers
- ☐ frequent earaches
- ☐ frequent nasal ulcers
- ☐ recent dental cavities or infection
- ☐ swelling or pain on sides of face

RESPIRATORY
- ☐ asthma
- ☐ chronic cough
- ☐ chest pain
- ☐ shortness of breath
- ☐ cough up sputum

ENDOCRINE
- ☐ thyroid disease
- ☐ diabetes mellitus

NEUROLOGIC
- ☐ headaches
- ☐ tingling in fingers
- ☐ seizures
- ☐ stroke
- ☐ pain, tingling or numbness in one leg
- ☐ muscle weakness

CARDIOVASCULAR
- ☐ angina
- ☐ heart attack
- ☐ heart murmur
- ☐ rheumatic fever
- ☐ fluid retention or swelling of feet
- ☐ abnormal heart rhythm
- ☐ phlebitis
- ☐ congestive heart failure
- ☐ high blood pressure

GASTROINTESTINAL
- ☐ stomach or duodenal ulcer
- ☐ heartburn
- ☐ difficulty swallowing
- ☐ nausea or vomitting
- ☐ chronic diarrhea
- ☐ abdominal pain
- ☐ weight loss
- ☐ gallstones
- ☐ jaundice
- ☐ hepatitis or liver disease
- ☐ bleeding from stomach or bowel

GENITOURINARY
- ☐ urinary burning
- ☐ urinary frequency
- ☐ blood in urine
- ☐ protein in urine
- ☐ sores or rash on penis or vagina
- ☐ discharge from penis or vagina
- ☐ miscarriages (#_____)
- ☐ kidney stones

CONSTITUTIONAL
- ☐ fevers
- ☐ fatigue
- ☐ difficulty sleeping
- ☐ illict drug use (past or present)

HEMATOLOGIC
- ☐ anemia
- ☐ low platelet count
- ☐ history of cancer

ALLERGIC
- ☐ allergy shots
- ☐ food allergies

PSYCHIATRIC
- ☐ depression

☐ NONE OF THE ABOVE

REVIEWED BY:

_____, M.D.

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Routine Assessment of Patient Index Data

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. please check the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	without ANY difficulty	with SOME difficulty	with MUCH difficulty	UNABLE to do
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. how much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

Signature: _____ Date: _____

Rev. 05/2021

Staff Review Initials:

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY AGENT

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

Virginia Advance Directive

I, _____,
willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows in this document.

This advance directive shall not terminate in the event of my disability.

PART I: APPOINTMENT OF AGENT

(CROSS THROUGH AND INITIAL IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

I hereby appoint _____,
(primary agent)
of _____

_____
(address and telephone number)

as my agent to make health care decisions on my behalf as authorized in this document. If the person I have appointed above is not reasonably available or is unable or unwilling to act as my agent, then I appoint

_____,
(alternate agent)
of _____

_____,
(address and telephone number)
to serve in that capacity.

I grant to my agent, named above, full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.