ARCKC LLC

Date of appointment ______________

Last Name ____________________ First ____________ Middle initial ______ Maiden __________
Birthdate ______________________________ Birthplace ________________ Male Female
Address ______________________________ City ________________ State ______ Zip ______
Home phone ______________ Cell ____________________ Work ____________________

Name of person making referral ____
Your primary physician ____
Your pharmacy ______________________________ Phone ____________________

Briefly describe your present symptoms ____
Date symptoms began ____________________ Duration of symptoms ____________________

PAST MEDICAL HISTORY

- ☐ Arthritis type unknown ____________
- ☐ Osteoarthritis ____________
- ☐ Rheumatoid ____________
- ☐ Gout ____________
- ☐ Lupus /SLE ____________
- ☐ Ankylosing spondylitis ____________
- ☐ Childhood arthritis ____________
- ☐ Osteoporosis ____________
- ☐ Fibromyalgia ____________
- ☐ Psoriasis ____________
- ☐ Crohn's ____________
- ☐ Asthma ____________
- ☐ Allergies ____________
- ☐ Hives ____________
- ☐ Food allergy ____________
- ☐ Eczema ____________
- ☐ Bronchitis ____________
- ☐ Pneumonia ____________
- ☐ Sinus problem ____________
- ☐ Headaches ____________
- ☐ Thyroid ____________
- ☐ Diabetes ____________
- ☐ Jaundice ____________
- ☐ Kidney disease ____________
- ☐ Epilepsy ____________
- ☐ Stroke ____________
- ☐ Heart problems ____________
- ☐ Cataracts ____________
- ☐ Anemia ____________
- ☐ Stomach ulcers ____________
- ☐ Tuberculosis ____________
- ☐ Cancer ____________
- ☐ Leukemia ____________

MAJOR ILLNESSES ____________

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____
____
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____
____

SURGERIES

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____
____
____
____
____
____

FRACTURES

____
____
____
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____
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____

FAMILY HISTORY --Has any blood relative had any of the following? If so state relationship?

- ☐ Arthritis type unknown ____________
- ☐ Osteoarthritis ____________
- ☐ Rheumatoid ____________
- ☐ Gout ____________
- ☐ Lupus /SLE ____________
- ☐ Ankylosing spondylitis ____________
- ☐ Childhood arthritis ____________
- ☐ Osteoporosis ____________
- ☐ Fibromyalgia ____________
- ☐ Psoriasis ____________
- ☐ Colitis ____________
- ☐ Asthma ____________
- ☐ Allergies ____________
- ☐ Hives ____________
- ☐ Food allergy ____________
- ☐ Eczema ____________
- ☐ Bronchitis ____________
- ☐ Pneumonia ____________
- ☐ Sinus problem ____________
- ☐ Headaches ____________
- ☐ Thyroid ____________
- ☐ Diabetes ____________
- ☐ Jaundice ____________
- ☐ Kidney disease ____________
- ☐ Epilepsy ____________
- ☐ Stroke ____________
- ☐ Heart problems ____________
- ☐ Cataracts ____________
- ☐ Anemia ____________
- ☐ Rheumatic fever ____________
- ☐ Tuberculosis ____________
- ☐ Cancer ____________
- ☐ Leukemia ____________

Name ________________________________

SOCIAL HISTORY

Marital status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Highest education level: K 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 Graduate school years _____

ALLERGIC REACTIONS TO – include medications, foods, other – if need additional space attach sheet)

Agent	Vomiting	Diarrhea	Short of Breath	Swelling/hives	Other rash	Treatment/date
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________
____________	☐	☐	☐	☐	☐	________________________

CURRENT MEDICATIONS (include over the counter, vitamins, etc – if need additional space may attach sheet)

Medication	Dose	If for arthritis is it helping?		
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some
____________________	____________________________	☐ Yes	☐ No	☐ Some

PAST MEDS ARTHRITIS PATIENTS ONLY

Medication	Helped	Reaction	Medication	Helped	Reaction
Aspirin	☐ Yes ☐ No	________________	Colchicine	☐ Yes ☐ No	________________
Ibuprofen	☐ Yes ☐ No	________________	Allopurinol	☐ Yes ☐ No	________________
Meloxicam	☐ Yes ☐ No	________________	Enbrel	☐ Yes ☐ No	________________
Celebrex	☐ Yes ☐ No	________________	Humira	☐ Yes ☐ No	________________
Hydroxychloroquine	☐ Yes ☐ No	________________	Remicade	☐ Yes ☐ No	________________
Sulfasalazine	☐ Yes ☐ No	________________	Orencia	☐ Yes ☐ No	________________
Methotrexate	☐ Yes ☐ No	________________	Actemra	☐ Yes ☐ No	________________
Prednisone	☐ Yes ☐ No	________________	Other	☐ Yes ☐ No	________________
Steroid injections	☐ Yes ☐ No	________________	Other	☐ Yes ☐ No	________________

ALLERGY/ASTHMA PATIENTS ONLY

Symptoms:	☐ spring	☐ fall	☐ all year			
Triggered by:	☐ smoke	☐ cold air	☐ odors	☐ infections	☐ exercise	☐ weather change
	☐ pets	☐ dust	☐ foods	☐ aspirin	☐ cosmetics	☐ other__________
Environment:	Home	☐ house	☐ apt	☐ age ___yrs	☐ basement	☐ crawlspace
	Heating/AC	☐ gas	☐ electric	☐ woodburning	☐ central a/c	☐ HEPA filter
	Bedroom	☐ carpeted	☐ wood	☐ tile	☐ basement level	☐ allergy covers
	Pets	☐ Dog	☐ Cat	☐ Other ______________________________		

ARCK Review Of Systems

New or update from last visit

(Check all that apply)

______________________________ patient name (Print)

General
- o Weight gain ______lbs
- o Weight loss ______lbs
- o Fever
- o Fatigue
- o Weakness

Nervous system
- o Headaches
- o Dizziness
- o Fainting
- o Muscle spasm
- o Sensitivity hands/ feet
- o Memory loss
- o Convulsions
- o Thinking problem

Eyes
- o Pain
- o Redness
- o Loss of vision
- o Double/blurred vision
- o dryness
- o Foreign body feeling
- o Watery
- o Itching

Ears
- o Ringing
- o Hearing loss

Nose
- o Nosebleeds
- o Loss of smell
- o Dryness
- o Itching of the nose
- o Post nasal drip
- o Congestion
- o Bad breath

Pharynx
- o Sore tongue
- o Bleeding gums
- o Sores in mouth
- o Loss of taste
- o Dry mouth
- o Frequent sore throat

Neck
- o Hoarseness
- o Difficulty swallowing
- o Swollen glands
- o Tender glands

Heart /Lungs
- o Cough
- o Wheezing
- o Cough with exertion
- o Shortness of breath
- o Night sweats
- o Coughing up blood
- o Chest pain
- o Irregular heart beat
- o Difficulty breathing at night
- o Swelling in feet
- o High blood pressure
- o Heart murmur

Stomach /Intestines
- o Nausea
- o Vomiting blood
- o Heartburn better w/food or meds
- o Yellow jaundice
- o Increasing constipation
- o Persistent diarrhea
- o Blood in stools
- o Black stools
- o Heart burn

Kidney/Urine/Bladder
- o Urine frequent
- o Pain during urination
- o Blood in urine
- o Urine Smokey
- o Pus in urine
- o Night urination
- o Vaginal discharge
- o Vaginal dryness
- o Skin rash genitals

Vaccine Booster Dates
PneumoVax: ____________

Varicella: ______________

Shingles: ______________

TB Test: ________________

Skin
- o Easy bruising tendency
- o Rash
- o Hives
- o Sensitivity to sunlight
- o Skin mobility tight
- o Nodules / bumps
- o Change in color of skin
- o Redness of the skin

Musculoskeletal
- o Morning stiffness lasting ________hours
- o Muscle weakness
- o Joint swelling
- o Joint pain
- o Tenderness in muscles

Habits
Number of pillows used for sleep_____
- o Sleep enough at night
- o Awakens refreshed

Blood
- o Anemia
- o Easy bleeding

Menstrual HX
- o Age at first period ______
- o Abnormal periods
- o Post menopausal bleeding

Last Pap smear ___________
- o Have had miscarriage
- o Taking oral contraceptive

Last menstruation_________

Endocrine
- o Thyroid problems
- o Hair loss of head/body

Psych
- o Hyperactive behavior
- o Attention problems
- o Unusual behavior
- o Highly irritable

Date of last:

Eye exam________________

Bone densitometry____________

ARCKC LLC

Name ______________________________ Date of Birth ____________________

To be completed at every visit

1. **SMOKING STATUS:** Patients 18 years of age and older

   PLEASE CHECK THE BOX THAT BEST IDENTIFIES YOU:

   - ☐ Never a Smoker
   - ☐ Current Every Day Smoker
   - ☐ Current Some Day Smoker
   - ☐ Former Smoker
   - ☐ Smoker-Current Status Unknown
   - ☐ Unknown if ever smoked
   - ☐ Smoking Cessation

2. **PNEUMONIA VACCINATION STATUS:** PLEASE CHECK ONE OF THE BOXES

   - ☐ Yes, I have had a Pneumococcal Vaccine

     Date vaccine was administered: ______________________________
   - ☐ No, I have NOT had a Pneumococcal Vaccine

3. **I WAS:** (PLEASE CHECK ALL THAT APPLY)

   - ☐ Referred by: ______________________________
   - ☐ Referred by Urgent Care Clinic
   - ☐ Referred by the Emergency Room
   - ☐ Referred Here For: ______________________________

4. **BREAST SCREENING:** Female Patients 50 years of age and older

   PLEASE CHECK ONE OF THE BOXES

   - ☐ Yes, I have had a Mammogram in the last 2 years

     Date Mammogram was performed: ______________________________
   - ☐ No, I have NOT had a Mammogram in the last 2 years

5. **COLORECTAL SCREENING:** Patients 50 to 75 years of age

   PLEASE CHECK ONE OF THE BOXES

   - ☐ Yes, I have had a Complete Colonoscopy performed in the last 10 years

     Date Complete Colonoscopy was performed: ______________________________
   - ☐ No, I have NOT had a Complete Colonoscopy performed in the last 10 years

Adults:	Answer all questions
Pediatrics:	Answer questions considering similar activities appropriate for your child's age.

Mark "0" if not applicable.

Name: ______________________________

Today's Date: mm [ ][ ] / dd [ ][ ] / yyyy [ ][ ][ ][ ]

Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING on the following scale. Place an X in the box below that best describes how you are doing on a scale of 0-10.

VERY WELL 0 ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ 10 VERY POORLY

We are also interested in learning whether or not you are affected by pain because of your illness. How much pain have you had because of your illness in the past week? Place an X in the box that a best describes the severity of your pain on a scale of 0-10.

NO PAIN 0 ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ 10 SEVERE PAIN

We are interested in learning how your illness affects your ability to function in your daily life. Place an X in the box which best describes your usual abilities OVER THE PAST WEEK:

Are you able to:	Without Any Difficulty (0)	With Some Difficulty (1)	With Much Difficulty (2)	Unable To Do (3)
Stand up from a straight chair?	□	□	□	□
Walk outdoors on flat ground?	□	□	□	□
Get on/off toilet?	□	□	□	□
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	□	□	□	□
Open car doors?	□	□	□	□
Do outside work (such as yard work)?	□	□	□	□
Wait in line for 15 minutes?	□	□	□	□
Lift heavy objects (over 40 pounds)?	□	□	□	□
Move heavy objects (over 40 pounds)?	□	□	□	□
Go up two or more flights of stairs?	□	□	□	□

We are interested in knowing about any problems that you may have been having with fatigue. How much of a problem has fatigue or tiredness been for you IN THE PAST WEEK? Place an X in the box below that best describes the severity of your fatigue on a scale of 0-10.

FATIGUE IS NO PROBLEM 0 ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ □ □ □ ○ 10 FATIGUE IS A MAJOR PROBLEM

How satisfied are you with your HEALTH NOW?

□ Very satisfied □ Somewhat satisfied □ Neither satisfied nor dissatisfied □ Somewhat dissatisfied □ Very dissatisfied

Please answer Allergy/Asthma questions on reverse side, if applicable

WHEEZING/ ASTHMA – ACT

Name ______________________

Doctor NYO AB JDA

IN THE PAST 4 WEEKS

Did asthma interfere with activities?

1	2	3	4	5
All the time	Most of the time	Some of the time	A little of the time	None of the time

How often has shortness of breath occurred?

1	2	3	4	5
More than once daily	Once a day	3 to 6 times per week	Once or twice a week	Not at all

How often has asthma/ chest symptoms caused night or morning waking?

1	2	3	4	5
More than 3 nights per week	2 or 3 nights per week	Once a week	Once or twice	Not at all

How often has rescue inhaler/ nebulizer been needed?

1	2	3	4	5
More than 2 times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all

Asthma control would be rated?

1	2	3	4	5
Not controlled	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled

Total ACT score __________

What does it mean?

Score 19 or less perhaps control could be improved.
Score 20 or more control may be good.

Please answer Rheumatology questions on reverse side, if applicable