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688 Millsap Rd, Fayetteville, AR 72703

Internal Medicine Associates
The entrance is at the back of the building overlooking the Fulbright Expressway

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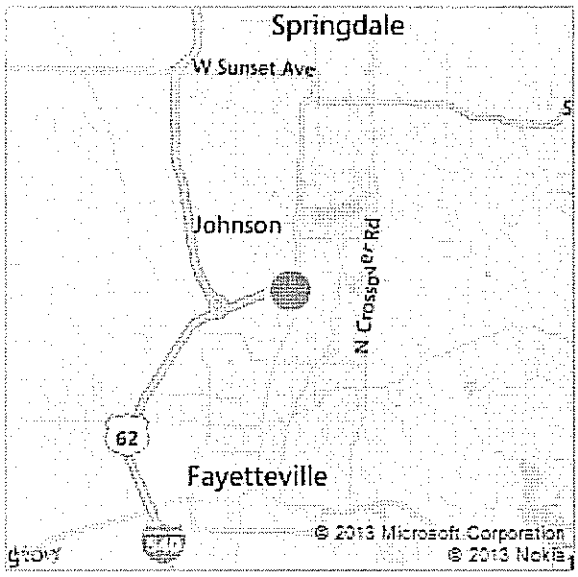

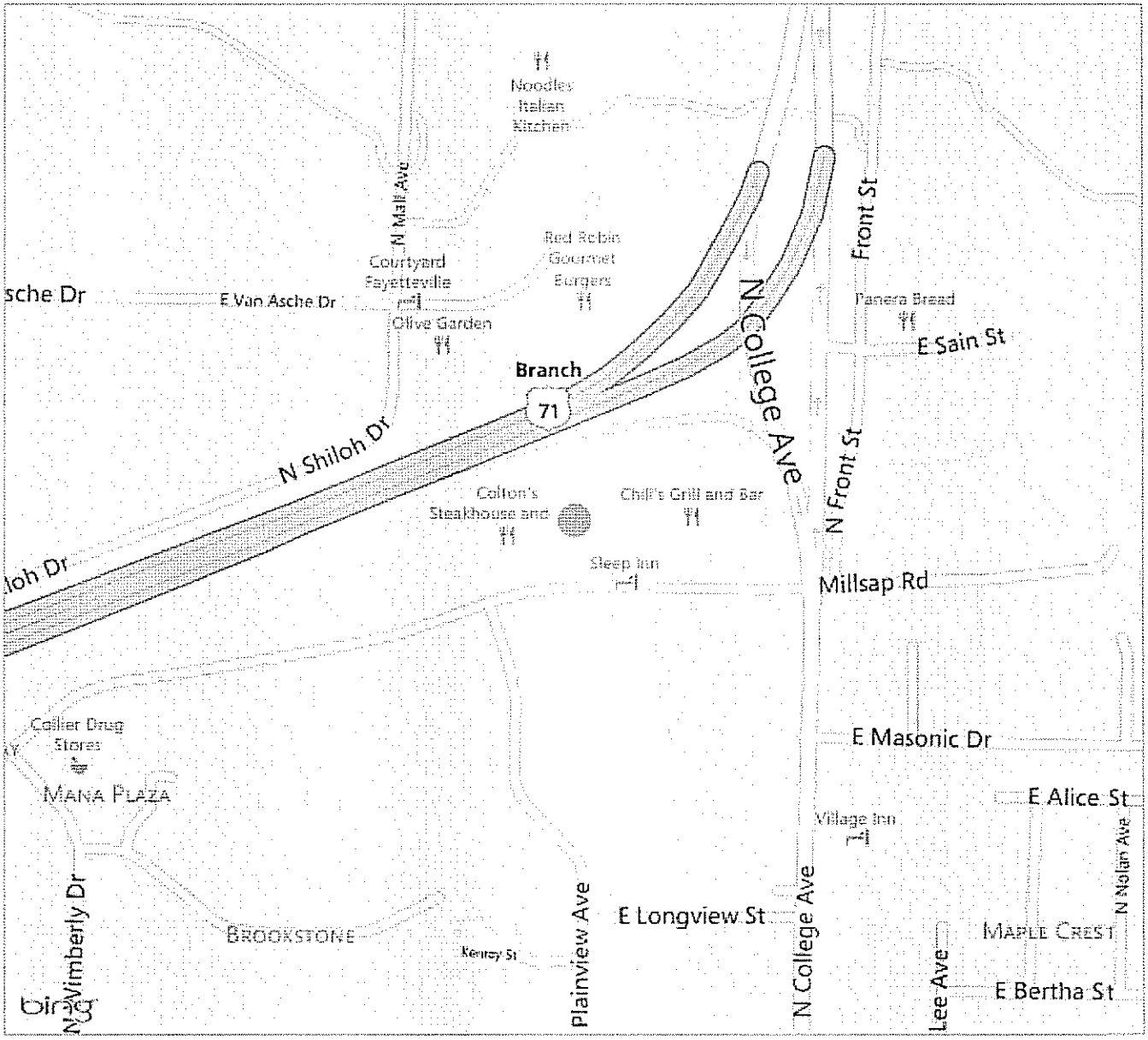

Internal Medicine
Associates
Washington Regional

Due to the expansion of Dr.Jessica Short's practice, as of January 1, 2014 we are updating our current policy regarding appointment times, late arrivals, and check in. You will need to check in 15 minutes prior to your scheduled appointment time. If you arrive after your appointment time, you could be asked to reschedule. If you are more than 10 minutes late, you will **need** to reschedule. Please allow driving time due to the road construction etc. This has always been her policy and due to the increase patient load we will be enforcing this policy to ensure that you are seen in a timely manner.

Upon arrival please be sure to check in with the receptionist at the front desk for your appointment, whether it is for lab, injections or doctor visit.

Please note, if you have lab ordered prior to your appointment that has not been done, we will need to reschedule the lab and doctor appointment. If you have lab done with an outside facility, other than Quest, we would ask you to bring a copy of those lab results with you to your appointment.

Thank you for your cooperation,

Washington Regional Internal Medicine Assoc.

Internal Medicine
Associates
Washington Regional

Thank you for choosing Washington Regional Rheumatology. In order to make your appointment more efficient, please take the time to fill out the enclosed history and personal information forms.

In order for our medical staff to determine your diagnosis and a treatment plan, you must bring any medical records pertaining to your current medical condition, **especially lab results and previous rheumatology records.** Also, please bring the following to your visit.

1. Insurance cards and any other insurance information needed.
2. Completed history and personal information forms.
3. All radiology studies, including reports **AND** the actual films or CD-ROM.
4. If you have seen a Rheumatologist in the past, please bring records or imaging from that physician.
5. You need to arrive 20-30 minutes before your scheduled appointment time. Please wear loose fitting clothing to where you can be easily examined. Shorts and t-shirts are preferred.
6. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule. If you cancel or do not show up for your appointment twice, you will need a new referral from your doctor.

Please be sure that we have a current day time phone number so we may contact you regarding any schedule changes.

We look forward to taking part in your healthcare. If you have any questions, please feel free to contact our office at 479-463-3070.

Sincerely,

Jessica Short, M.D

DATE:_____ **TIME:**_____**am/pm**

Internal Medicine Associates
Washington Regional

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____-_____-_____ MRN#:_____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____Ext:_____

Address: _____

Cell Phone: _____

City: _____

Date of Birth: _____-____-_____ Age: _____yrs

State: _____ Zip Code: _____

Employer: _____

SEX: θ Male θ Female

Work Address: _____

City: _____ State: ____ Zip: _____

MARITAL STATUS: θ Married θ Single θ Divorced
θ Partner θ Widowed Separated☐

Occupation: _____

Email:_____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

θ Washington Regional Medical Center
θ Community or Company Health Fair
θ Referred by a Physician: _____
θ Newspaper or Magazine
θ Treated by Physician in hospital
θ Employer
θ Recommended by friend or family member
θ Internet
θ Insurance Plan Directory
θ Drove by Location of Clinic
θ Phone Directory (Yellow pages)
θReturn Patient/ Not Applicable
θ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____

Cell: _____

Employer: _____

Work: _____ Ext: _____

Work Address: _____

Spouse/Parent SEX: θ Male θ Female

City: _____State: _____ Zip: _____

Spouse/Parent Date of Birth: _____/_____/_____

Occupation: _____

Social Sec. #: _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____

Cell Phone: _____

Address: _____

Home Phone: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

PRIMARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: θ Myself θ Spouse θ Child θ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ Main Holder's Date of Birth: ____/____/____

Main Holder's Address: _____ Main Holder's Soc Sec#: _____-_____-_____

City: _____

State: _____ Zip: _____

SECONDARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: θ Myself θ Spouse θ Child θ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ Main Holder's Date of Birth: ____/____/____

Main Holder's Address: _____ Main Holder's Soc Sec#: _____-_____-_____

City: _____

State: _____ Zip: _____

GENERAL INFORMATION

Who is responsible for Payment?: θ Myself θ Other:_____ (FILL OUT BELOW)

Responsible Party Name: _____ Responsible Party DOB: ____/____/____

Relationship to Patient: θSelf θSpouse θChild θOTHER SS#_____-_____-_____

Address: _____ Phone#:_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? θ Yes No

If Yes, When?:_____/_____/_____ Where?:_____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Preferred Language: θEnglish θSpanish θMarshallese θArabic θDECLINE OTHER: _____

Race: θ White θAfrican American θ Asian θ Native Hawaiian/Other Pacific Islander
θ Native American Indian/ Alaskan θHispanic θUnknown θ DECLINE

Ethnicity (Origin): θ Not Hispanic or Latino θ Hispanic or Latino θUnknown θDECLINE

Preferred Communication Method: θPrint θSave to Flash Drive θDECLINE

Wellness Reminders: θMail θCell Phone θHome phone θWork Phone θDECLINE

PREFERRED PHARMACY: _____ LOCATION: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ Date: _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ DATE: _____

This questionnaire is to get information that would help in the assessment of your health problem (s). Please try to answer each question, even if you do not think it is related to you at this time. Thank you.

1. PAST MEDICAL HEALTH:

Have you ever been told by a doctor/healthcare provider that you have any of the following? (If "yes" check the appropriate box)

☐ Diabetes ☐ High blood pressure ☐ High Cholesterol
☐ Heart Attack ☐ Angina ☐ Congestive Heart Failure
☐ Other heart disease (please describe) _____
☐ Asthma ☐ COPD/Emphysema ☐ Acid reflux or GERD
☐ Peptic ulcer disease ☐ Hepatitis ☐ Crohn's Disease/Ulcerative Colitis
☐ Blood clots in legs or lungs ☐ Peripheral vascular disease ☐ Thyroid disease
☐ Kidney disease ☐ Depression ☐ Anxiety or Panic disorder
☐ Stroke or Mini Stroke ☐ Epilepsy (Seizures)
☐ Neurological disease such as Multiple Sclerosis or Parkinson's disease
☐ Chronic back pain [degenerative disc disease spinal stenosis]
☐ Visual impairment such as cataract, glaucoma, or macular degeneration
☐ Hearing impairment such as very hard of hearing even with hearing aids
☐ Cancer (please describe) _____
☐ Other significant illnesses (please list) _____
Please list any surgeries or operations that you have had: _____
_____

Please record your current Weight _____ Height _____

2. SOCIAL/PERSONAL HISTORY:

- What is you highest education level? ☐ Grade School ☐ High School ☐ Some college courses ☐ College graduate ☐ Advanced degree
- At this time are you? ☐ Working full time ☐ Working part time ☐ Unemployed ☐ Retired ☐ Student ☐ Homemaker-full time
  Current or past occupation (s) _____
- Are you currently on disability or SSI? ☐ Yes ☐ No
- Marital Status ☐ Never married ☐ Married ☐ Divorce ☐ Separated ☐ Widowed
- Have you ever smoked on a regular basis? ☐ Yes ☐ No
  How many packs did (do) you smoke per day? ___ At what age did you start smoking? _____
  Do you smoke at this time? ☐ No ☐ Yes If "No", at what age did you stop smoking? _____
- Do you drink alcohol? ☐ Yes ☐ No If "Yes", type of drink _____ Number/week _____
- Have you used drugs for any reasons that are not medical? ☐ Yes ☐ No
  If "Yes" please list _____

RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ DATE: _____

3. We are interested in learning how your illness affects your ability to function in daily life. Place and "X" in the box that 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 and off the toilet?	☐	☐	☐	☐
Reach and get down a 5-pound object (such as bag of sugar) from just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Wait in line for 15 minutes?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐
Go up 2 or more flight of stairs?	☐	☐	☐	☐
Get a good night's sleep?	☐	☐	☐	☐
Deal with the usual stresses of daily life?	☐	☐	☐	☐
Deal with feelings of anxiety or being nervous?	☐	☐	☐	☐
Deal with feelings of depression or feeling blue?	☐	☐	☐	☐

FOR OFFI USE ON

1. FCN (C

1-0.3 1E
2-0.7 17
3-1.0 1E
4-1.3 1E
5-1.7 2[illegible]
6-2.0 21
7-2.3 22
8-2.7 23
9-3.0 24
10-3.3 25
11-3.7 2[illegible]
12-4.0 27
13-4.3 2[illegible]
14-4.7 2[illegible]
15-5.0 3[illegible]

2. PAIN

3. PTGL

RAPID3

4. How much pain have you had OVER THE PAST WEEK? Circle below to indicate how severe your pain has been:

no pain 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 pain as bad as it could be

5. Considering all the ways in which illness and health conditions may affect you at this time, please circle below to show how you are doing:

very well 0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 very poorly

RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ DOB:_____ DATE:_____

6. REVIEWS OF SYSTEMS

Please check any problems that may have significantly affected you:

General:
☐ Fatigue ☐Fever ☐ Loss of appetite
☐ Recent weight loss; how much_____ ☐ Recent weight gain; how much_____

Eyes:
☐ Redness ☐ Eye pain ☐ Decreased vision
☐ Daily, troublesome dry eyes for more than 3 months ☐ Recurrent sensation of gravel or sand in eyes
☐ Use tear drops more than 3 times a day ☐Any history of eye inflammation (i.e uveitis, iritis ect.

ENT:
☐Problems with hearing ☐Ear pain ☐Frequent sinus infections
☐Sores in mouth or nose ☐Daily feeling of dry mouth for more than 3 months
☐Need to frequently drink liquids to help in swallowing dry food

Neck:
☐Lumps ☐Swollen glands ☐Thyroid Problems

Respiratory:
☐Chest pain with deep breathing (i.e pleurisy) ☐Cough
☐Shortness of breath ☐Wheezing ☐Coughing of blood

Cardiovascular
☐Chest pain ☐Palpitation ☐Shortness of breath with activity
☐Difficulty breathing on lying flat ☐Leg swelling (edema)

Gastrointestinal:
☐Heartburn ☐Nausea ☐Vomiting ☐Swallowing difficulties
☐Stomach or abdomen pain ☐Constipation ☐Diarrhea ☐Blood in stools

Genito-urinary:
☐Increased urinary frequency ☐Burning or pain on urination ☐Blood in urine
For women only:
Do you have menstrual period? ☐Yes ☐No Number of pregnancies_____ Miscarriages_____

Neurologic:
☐Headaches ☐Numbness or tingling in arms/legs ☐Weakness in arms/legs
☐Memory loss ☐Difficulty in thinking or concentration

Skin:
☐Rash on cheeks (butterfly shaped) ☐Other rashes ☐Rash or feeling sick after going out in sun
☐Bald patches on scalp, or clumps of hair on pillow ☐Skin color changes in fingers/toes with cold exposure

Hematologic:
☐Unusual bruising or bleeding ☐Any h/o low blood counts (e.g. low platelets)

Musculoskeletal:
☐Joint pain ☐Joint swelling ☐Muscle pain or aches ☐Muscle weakness

RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ DOB: _____ DATE: _____

7. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle below to indicate your fatigue:

fatigue is	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	major
no problem	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10 problem

8. When you awakened in the morning OVER THE PAST WEEK, did you feel stiff? ☐ Yes ☐ No
If "yes" please write the number of minutes _____ or hours _____ until you are as limber as you will be for the day. Also, describe the overall level of stiffness that you have had when you wake up.

None	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	Very
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10 Severe

Please inform us of any major health problems in your family members:
Father _____
Mother _____
Sibling(s) _____
Others _____

MEDICATIONS

What medicines are you taking? Please list BOTH prescription and non-prescription.

1. _____ Dose _____ Times per day _____ How long _____
2. _____ Dose _____ Times per day _____ How long _____
3. _____ Dose _____ Times per day _____ How long _____
4. _____ Dose _____ Times per day _____ How long _____
5. _____ Dose _____ Times per day _____ How long _____
6. _____ Dose _____ Times per day _____ How long _____

Are you allergic to any medications? _____

Physician Signature: _____ Date: _____ Time: _____