Dorothy LaCombe Adult Healthcare Nurse Practitioner

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Patient History Form

Date of first appointment: ____/____/____ (month / day / year) Time of appointment: _____ Birthplace: _____

Name: _____ (last / first / middle initial / maiden) Birthdate: ____/____/____ (month / day / year)

Address: _____ (street / apt #) Age _____ Sex: ❑ F ❑ M

_____ (city / state / zip) Telephone: Home: (____) _____ Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

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

_____

_____

_____

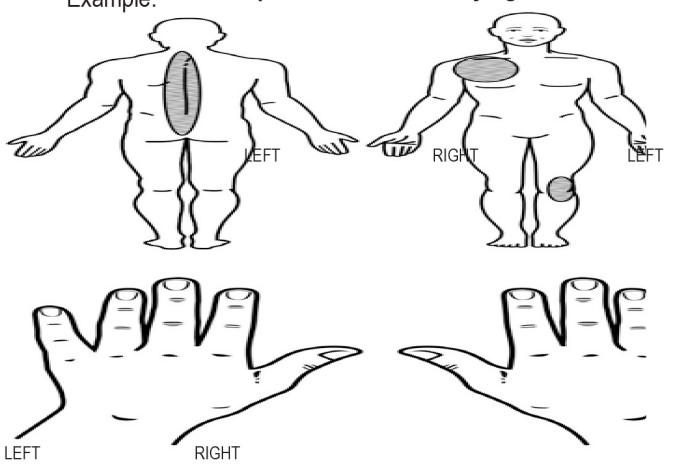
Please list the names of other practitioners you have seen for this problem:

_____

_____

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

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions: _____

Patient's Name: _____ Date: _____ Provider Initials: _____

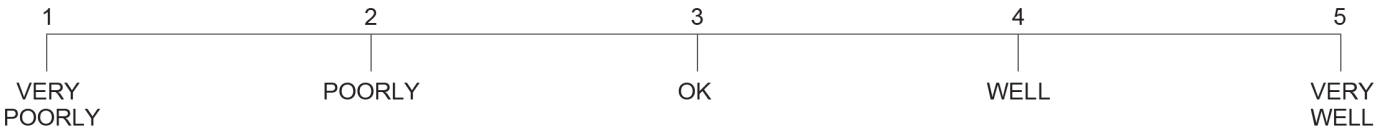
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No *If yes, how many?*

How many people in household? _____ Relationship and age of each _____

Who does most of the housework? _____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.)	❑	❑	❑
Walking?	❑	❑	❑
Climbing stairs?	❑	❑	❑
Descending stairs?	❑	❑	❑
Sitting down?	❑	❑	❑
Getting up from chair?	❑	❑	❑
Touching your feet while seated?	❑	❑	❑
Reaching behind your back?	❑	❑	❑
Reaching behind your head?	❑	❑	❑
Dressing yourself?	❑	❑	❑
Going to sleep?	❑	❑	❑
Staying asleep due to pain?	❑	❑	❑
Obtaining restful sleep?	❑	❑	❑
Bathing?	❑	❑	❑
Eating?	❑	❑	❑
Working?	❑	❑	❑
Getting along with family members?	❑	❑	❑
In your sexual relationship?	❑	❑	❑
Engaging in leisure time activities?	❑	❑	❑
With morning stiffness	❑	❑	❑
Do you use a cane, crutches, walker or wheelchair? *(circle one)*	❑	❑	❑

What is the harde st thing for you to do? _____

Are you receiving disability? ..... Yes ❑ No ❑

Are you applying for disability? ..... Yes ❑ No ❑

Do you have a medically related lawsuit pending? ..... Yes ❑ No ❑

Patient's Name: _____ Date: _____ Providers Initials: _____

PATIENT CONSENT AND WAIVER FORM

I, _____, understand that I am or will be responsible for all charges associated with today's visit and any subsequent visits relating to the diagnosis, testing, and treatment of any conditions, including but not limited to the following items:

- **NO REFERRAL AT TIME OF VISIT:** If you did not bring or have a valid insurance authorization referral (if your insurance requires one) at the time of your visit and still wish to be seen, you will be responsible for all charges.

- **NO INSURANCE:** You will be responsible for all charges associated with all visits.

- **MISSED APPOINTMENTS:** All patients receive a reminder call prior to the appointment as a courtesy. If an appointment is cancelled up to 24 hours prior to your appointment, you will not be charged. If you fail to show for your appointment, you will be charged $50.00. If you fail to show for your new patient appointment you will be charged $100.00.

- **CHANGES IN INSURANCE:** All co-pays and fees are due in full at time of service.

- **DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing cost and processing fees.

- **DISABILITY FORMS:** A fee will be assessed for any disability forms brought into the office. Fee will be determined by the Practitioner.

_____ _____

Patient's Signature or Responsible Party Date