



Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D.  
Theerapol Prasertsuntarasai, M.D. | Autumn Beasley, F.N.P.

Dear \_\_\_\_\_,

Welcome to the Arthritis & Osteoporosis Associates, L.L.P. family! Our mission is to provide quality and compassionate medical care for patients of the South Plains with rheumatic diseases. As our patient, we put *you* first and realize that our purpose is to improve *your* life. Please do not hesitate to ask any questions regarding procedures, policies, or forms that must be completed for your visit.

An appointment has been scheduled with Dr. Prasertsuntarasai for you on \_\_\_\_\_ at \_\_\_\_\_.

Please complete the attached questionnaire and bring it with you on the date of your appointment. Please **DO NOT MAIL** the questionnaire back to us. If you are unable to keep this appointment please contact our office within 24 hours of your appointment time. Broken appointments prevent other patients from receiving timely care. If you fail to keep this appointment you may be billed \$75.00.

Please bring all X-Ray, CT, MRI films, labs and progress notes from any physician that pertains to this visit. The doctor will review these films and reports at the time of your visit.

1. All insurance co-pays and deductibles are due at the time of service. This will range from \$500 to \$1500. This estimate DOES include labs, x-rays, injections performed in our office.
2. All private pay patients will be required to pay in full at the time of service. This will range from \$500-\$1500. This estimate DOES include labs, x-rays, injections performed in our office.
3. We will not file any non-contracted insurance. Patient is responsible for payment in full at the time of service. Please contact the office if you have any questions regarding your insurance plan. If your insurance plan requires a referral from you Primary Care Physician, you are responsible for obtaining the referral before your appointment. If your referral is not received prior to your appointment, you will be asked to reschedule.
4. **If your care requires lab work and/or x-rays, it is possible that you may receive a separate bill from our lab vendor or x-ray vendor since all tests are not done in our practice.**
5. Please bring someone to interpret if you cannot speak English. If you are a nursing home resident, a family member or nursing home attendant must accompany and stay with you through the duration of the appointment.

Thank you for your cooperation and understanding and for choosing Arthritis & Osteoporosis Associates. We look forward to caring for you.

Signature \_\_\_\_\_ Date: \_\_\_\_\_



Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D.  
Theerapol Prasertsuntarasai, M.D. | Autumn Beasley, F.N.P.

To Our Patients:

The physicians of Arthritis & Osteoporosis Associates, Dr. Bushan, Dr. Calmes, Dr. Del Giudice, and Dr. Prasertsuntarasai wish to inform you that they do not attend or consult patients in the hospital. We will, of course, be available to consult by phone with the attending physician and other consultants regarding the hospital care of our patients for continuity of medications and to discuss our patients' rheumatologic diagnosis. One of our physicians will always be on telephone call to advise you regarding problems or emergencies that may arise after hours or on weekends. We do advise each of you to have a personal primary care physician to direct your hospital needs and coordinate appropriate consultations in the hospital.

The face of rheumatology practice is changing nationwide and the trend is for practicing rheumatologists to focus on the outpatient care of our patients. We continue to strive to provide state of the art care of your rheumatic diseases in our outpatient clinic and our time and energies need to be directed toward the care of our office patients. We are adding new technologies in our practice with addition of musculoskeletal ultrasound. We continue to have a very active clinical research department participating in several clinical trials involving new and exciting therapies for the diseases we treat.

As always, we continue to be committed to providing quality care for our patients and are dedicated to making your experience in our outpatient clinic a pleasant experience. We thank you for your loyalty as we partner in your medical care.

Sincerely,

Naga Bushan, M.D.

Jose Del Giudice, M.D.

Michael Calmes, M.D.

Theerapol Prasertsuntarasai, M.D.

**\*Please note: This office DOES NOT prescribe Schedule III narcotics including Hyrdcodone\*  
It is the repsonsibility of the patient to know his/her insurance benefits. Please call your insurance  
company if you are unsure of your benefit coverage prior to confirming an appointment.**

**Arthritis & Osteoporosis Associates, L.L.P.**  
**Theerapol Prasertsuntarasai, M.D.**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ AGE: \_\_\_\_\_ Sex:  Male  Female  
Current Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #:(\_\_\_\_\_) \_\_\_\_\_ Work#:(\_\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_\_) \_\_\_\_\_  
RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT:  Self  Spouse  Child  Other: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Patient's Marital Status:  Minor  Single  Married  Separated  Divorced  Widowed  
Status:  Employed  Student Employer/School: \_\_\_\_\_ Phone#:(\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
IN CASE OF AN EMERGENCY, PLEASE CONTACT: \_\_\_\_\_ Phone #:(\_\_\_\_\_) \_\_\_\_\_

**IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female  
Permanent Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #:(\_\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_\_) \_\_\_\_\_  
Employed:  Yes  No Employer: \_\_\_\_\_ Phone #:(\_\_\_\_\_) \_\_\_\_\_  
Marital Status:  Minor  Single  Married  Separated  Divorced  Widowed

**MEDICAL INSURANCE/MEDICARE/MEDICAID INFORMATION:**

Type of Medical Insurance:  Private Insurance  Medicare  Medicaid  Workers Comp  Other: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Phone #:(\_\_\_\_\_) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Identification #: \_\_\_\_\_ GROUP NAME/#: \_\_\_\_\_  
Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Employer Plan?  Yes  No Birthdate: \_\_\_\_\_ Sex:  Male  Female  
Do you have a secondary form of insurance?  Yes  No Company Name: \_\_\_\_\_  
Phone #:(\_\_\_\_\_) \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Arthritis & Osteoporosis Associates, L.L.P.**  
**Theerapol Prasertsuntarasai, M.D.**

**Patient Financial Agreement**

**PATIENT NAME:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

*Arthritis & Osteoporosis Associated, L.L.P. appreciates the confidence you have shown in choosing us to provide for your medical needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for payment in full. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for the balance in full.*

*You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.*

I have read the above policy regarding my financial responsibility to *Arthritis & Osteoporosis Associates, L.L.P.* for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of the bill incurred by me or the above name patient; or, if applicable any amount due after payment has been made by my insurance carrier.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(If guarantor is not the patient)

**CO-PAY POLICY**

Some health carriers require the patient to pay a co-pay for services rendered. You will be responsible for any copay required for each visit. Thank you for your cooperation in this matter.

**PATIENT/GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MEDICARE AUTHORIZATIONS**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap or Medicare Advantage benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these payable for related services.

**PATIENT/RESPONSIBLE PARTY SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Patient Financial Agreement (continued)**

**MEDICAID/PCCM**

If the referring physician on my monthly Medicaid card changes, it is my responsibility to obtain the required referral for my appointment with *Arthritis & Osteoporosis Associates, L.L.P.* If I fail to obtain my required referral I understand that my appointment will be rescheduled with no exceptions.

**PATIENT/GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SELF-PAY**

I do not have health insurance and will be responsible for services rendered here at *Arthritis & Osteoporosis Associates, L.L.P.* I agree to pay *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of treatment given to me or to the above named patient at each visit.

**PATIENT/GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**REFERRAL POLICY**

As described in my contract with my insurance company, if a referral is required for my visit to an *Arthritis & Osteoporosis Associates, L.L.P.* specialist, I am responsible for obtaining the referral. If I fail to obtain my required referral, I understand that my appointment will be rescheduled with no exceptions.

**PATIENT/GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CANCELLATION/NO SHOW POLICY**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment. If you fail to cancel your appointment within 24 hours, you may be charged \$75.00.

I understand if I no show for two consecutive patient appointments or no show for four follow-up appointments, I will be discharged from medical care.

*Arthritis & Osteoporosis Associates, L.L.P.* will notify you in writing via certified mail if you are discharged from medical care.

I have read and understood the above information and I agree to the terms described.

**PATIENT/GUARANTOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Arthritis & Osteoporosis Associates, LLP.

## Consent for Use and Disclosure of Health Information:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER ( check all that apply)

Home Telephone: \_\_\_\_\_

- Leave a detailed message  
 Leave a message with call back number only

Work Telephone: \_\_\_\_\_

- Leave a detailed message  
 Leave a message with call back number only

Written Communication:

- Mail to home address  
 Mail to work/ office address

Other: ( spouse,child,etc.)  
(Please list names of individuals we have consent to speak with regarding your care)

Fax to this number: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Acknowledgment of Receipt of Notice of Privacy Practices:

You have the right to read our Notice of Policy Practices before you sign this consent. Our notice provides description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available. Which will contain the changes.

### AGREEMENT AS TO GOVERNING LAW AND FORUM:

The Patient and healthcare provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any healthcare rendered to patient: and (2) in the event of a dispute any lawsuit, action of cause action which in any way relates to the healthcare provided to patient shall only be brought in a Texas District Court in the county of where all or substantially all of the healthcare was provided or rendered and in no law and forum selection provisions of this paragraph are mandatory and are not permissive.

By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PATIENT OR PERSONAL REPRESENTATIVE)

PRINT NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT ( if signed by personal representative ): \_\_\_\_\_

# Arthritis & Osteoporosis Associates, L.L.P.

## Theerapol Prasertsuntarasai, M.D.

### Patient History Form (Rheumatology)

Date of appointment: \_\_\_/\_\_\_/\_\_\_ Time of appointment: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Home #:(\_\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_\_) \_\_\_\_\_

Marital Status:  Never married  Married  Divorced  Separated  Widowed

Spouse/Significant Other:  Alive/age: \_\_\_\_\_  Deceased/age: \_\_\_\_\_ Major illness: \_\_\_\_\_

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 week: \_\_\_\_\_

Referred by:  Self  Family  Friend  Doctor  Other health profession

Name of person making referral: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Do you have an orthopedic surgeon?  Yes  No

If yes, name: \_\_\_\_\_

Describe briefly your present symptoms: \_\_\_\_\_

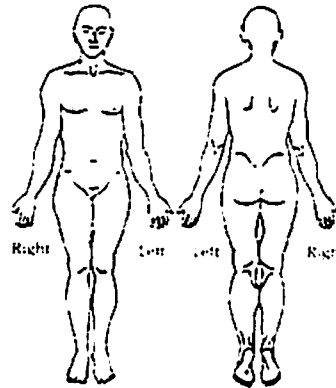
\_\_\_\_\_

Date symptoms began: \_\_\_/\_\_\_/\_\_\_

Previous treatment for this problem (include physical therapy, surgery & 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.



#### RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself	Relative/Relation	Yourself	Relative/Relation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other arthritis conditions: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

# Patient History Form (continued)

## SOCIAL HISTORY

Do you drink caffeinated beverages?  Yes  No  
 Cup/glasses per day: \_\_\_\_\_  
 Do you smoke?  Yes  No  Past How long? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No # per week? \_\_\_\_\_  
 Has anyone ever told you to cut down on your drinking?  
 Yes  No

Do you use drugs for reasons that are not medical?  
 Yes  No If yes please list: \_\_\_\_\_  
 \_\_\_\_\_

Do you exercise regularly?  Yes  No  
 Type: \_\_\_\_\_  
 Amount per week: \_\_\_\_\_  
 How many hours of sleep do you get at night? \_\_\_\_\_  
 Do you get enough sleep at night?  Yes  No  
 Do you wake up feeling rested?  Yes  No

### Previous operations:

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures?  Yes  No Describe: \_\_\_\_\_  
 Any other serious injuries?  Yes  No Describe: \_\_\_\_\_

### Family History:

	Age	If Living Health	Age of Death	If Deceased Cause
Father				
Mother				

Number of siblings: \_\_\_\_\_ Number of living: \_\_\_\_\_ Number or deceased: \_\_\_\_\_  
 Number of children: \_\_\_\_\_ Number of living: \_\_\_\_\_ Number of deceased: \_\_\_\_\_ List ages of each: \_\_\_\_\_  
 Health of children: \_\_\_\_\_

### Do you know of any blood relative who has or had: (check and give relationship)

Cancer \_\_\_\_\_  Heart disease \_\_\_\_\_  Rheumatic Fever \_\_\_\_\_  Tuberculosis \_\_\_\_\_  
 Leukemia \_\_\_\_\_  High blood pressure \_\_\_\_\_  Epilepsy \_\_\_\_\_  Diabetes \_\_\_\_\_  
 Stroke \_\_\_\_\_  Bleeding tendency \_\_\_\_\_  Asthma \_\_\_\_\_  Goiter \_\_\_\_\_  
 Colitis \_\_\_\_\_  Alcoholism \_\_\_\_\_  Psoriasis \_\_\_\_\_  Osteoporosis \_\_\_\_\_

Are you receiving disability?  Yes  No Are you applying for disability?  Yes  No  
 Do you have a medically related lawsuit pending?  Yes  No

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

## PAST MEDICAL HISTORY

Do you now or have you ever had: (check if yes)  
 Cancer  Heart problems  Asthma  
 Goiter  Leukemia  Stroke  
 Cataracts  Diabetes  Epilepsy  
 Nervous  High blood  Rheumatic  
 breakdown pressure fever  
 Headaches  Jaundice  Colitis  
 Kidney  Pneumonia  Psoriasis  
 disease  
 Anemia  Stomach ulcers  HIV/AIDS  
 Emphysema  Glaucoma  Tuberculosis  
 Other significant illness (please list):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# Arthritis & Osteoporosis Associates, L.L.P.

Theerapol Prasertsuntarasai, M.D.

## Systems Review

As you review the following list, please check any of the problems which have significantly affected you.

Date of last mammogram: \_\_\_/\_\_\_/\_\_\_    Date of last eye exam: \_\_\_/\_\_\_/\_\_\_    Date of last chest X-ray: \_\_\_/\_\_\_/\_\_\_  
Date of last TB test: \_\_\_/\_\_\_/\_\_\_    Date of last bone densitometry: \_\_\_/\_\_\_/\_\_\_

### Constitutional

Recent weight gain/amount: \_\_\_\_\_  
 Recent weight loss/amount: \_\_\_\_\_

Fatigue

Weakness

Fever

### Eyes

Pain

Redness

Loss of vision

Double or blurred vision

Dryness

Feels like something in eyes

Itching eyes

### Ears/Nose/Mouth/Throat

Ringing in ears

Loss of hearing

Nosebleeds

Loss of smell

Dryness in nose

Runny nose

Sore tongue

Bleeding gums

Sores in mouth

Loss of taste

Dryness of mouth

Frequent sore throats

Hoarseness

Difficulty swallowing

### Cardiovascular

Pain in chest

Irregular heart beat

Sudden changes in heart beat

High blood pressure

Heart murmurs

### Respiratory

Shortness of breath

Difficulty in breathing at night

Swollen legs or feet

Cough

Coughing of blood

Wheezing (asthma)

### Gastrointestinal

Nausea

Vomiting of blood

Stomach pain relieved with food

Jaundice

Increasing constipation

Persistent diarrhea

Blood in stools

Black stools

Heartburn

### Genitourinary

Difficult urination

Pain or burning on urination

Blood in urine

Cloudy, "smoky" urine

Pus in urine

Discharge from penis/vagina

Getting up at night to urinate

Vaginal dryness

Rash/ulcers

Sexual difficulties

Prostate trouble

### For women only

Age when periods began: \_\_\_\_\_

Periods regular?  Yes  No

How many days apart? \_\_\_\_\_

Date of last period: \_\_\_/\_\_\_/\_\_\_

Date of last pap: \_\_\_/\_\_\_/\_\_\_

Bleeding after menopause?

Yes  No

Number of pregnancies: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

### Musculoskeletal

Morning stiffness

    Lasting how long? \_\_\_ min \_\_\_ hrs

Joint pain

Muscle weakness

Muscle tenderness

Joint swelling

List joints affected in the last 6 mo.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Integumentary

Easy bruising

Redness

Rash

Hives

Sun sensitive (sun allergy)

Tightness

Nodules/bumps

Hair loss

Color changes of hands or feet in the cold

### Neurological System

Headaches

Dizziness

Fainting

Muscle spasm

Loss of consciousness

Sensitivity or pain of hands and/or feet

Memory loss

Night sweats

### Psychiatric

Excessive worries

Anxiety

Easily losing temper

Depression

Agitation

Difficulty falling asleep

Difficulty staying asleep

### Endocrine

Excessive thirst

### Hematologic/Lymphatic

Swollen glands

Tender glands

Anemia

Bleeding tendency

Blood transfusion/when? \_\_\_\_\_

### Allergic/Immunologic

Frequent sneezing

Increased susceptibility to infection

Date \_\_\_\_\_ Initials \_\_\_\_\_

**Arthritis & Osteoporosis Associates, L.L.P.**  
**Theerapol Prasertsuntarasai, M.D.**

**Medications**

Drug allergies:  Yes  No to what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**Current medications** (list any medications you are currently taking including over-the-counter medications)

Name of drug	Dose (include strength & # of pills per day)	How long have you taken this medication?	Helped A lot	Helped Some	Helped Not at all

**Past Medications:** Please review this list of medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had.

Drug Names	Length of time	Has this helped?			Reactions
		A lot	Some	Not at all	

**Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)**

Ansald (flurbiprofen)					
Daypro (oxaprozin)					
Meclomen (meclofenamate)					
Tolectin (tolmetin)					
Voltaren (diclofenac)					
Arthrotec (diclofenac + misorostil)					
Disalcid (salsalate)					
Motrin (ibuprofen)					
Trilisate (choline magnesium trisalicylate)					
Clinoril (sulindac)					
Aspirin					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Nalfon (fenoprofen)					
Lodine (etodolac)					
Vioxx (rofecoxib)					
Celebrex (celecoxib)					
Indocin (indomethacin)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Mobic (meloxicam)					
Relafen (nabumetone)					

**Pain Relievers**

Tylenol (acetaminophen)					
Codeine (Tylenol #3)					
Norco, Lortab (hydrocodone)					
Ultram, Ultracet (tramadol)					

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

## Medications (continued)

### Disease Modifying Antirheumatic Drugs (DMARDs) or Immunosuppressive Drugs:

Auranofin (ridaura-gold pills)					
Myochrysin (gold shots)					
Plaquenil (hydroxychloroquine)					
Cuprimine/Depen (penicillamine)					
Rheumatrex (methotrexate)					
Arava (leflunomide)					
Imuran (azathioprine)					
Azulfidine (sulfasalazine)					
Atabrine (quinacrine)					
Cytosan (cyclophosphamide)					
Sandimmune/Neora (cyclosporine)					
Enbrel (etanercept)					
Humira (adalimumab)					
Simponi (golimumab)					
Cimzia (certolizumab)					
Remicade (infliximab)					
Orencia (abatacept)					
Actemra (tocilizumab)					
Benlysta (belimumab)					
Prosorba Column					
Xeljanz					

### Osteoporosis Medications:

Premarin (estrogen)					
Fosamax (alendronate)					
Actonel (residronate)					
Didronel (etidronate)					
Evista (raloxifene)					
Fluoride					
Miacalcin (calcitonin injections)					
Boniva (ibandronate)					
Prolia (denosumab)					
Reclast (zoledronic acid)					
Forteo (teriparatide)					

### Gout Medications:

Benemid (probenecid)					
Colcrys (colchicine)					
Zyloprim/Lopurin (allopurinol)					
Uloric (febuxostat)					
Krystexxa (pegloticase)					

### Others:

Prednisone (cortisone)					
Hyalgan/Synvisc/Supartz					

Have you participated in any clinical trials for new medications?  Yes  No

If yes, list: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

**ARTHRITIS & OSTEOPOROSIS ASSOCIATES, L.L.P.**  
**Rapid 3 Assessment Questionnaire**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

This questionnaire is designed to receive information from you to provide a record of your current health status. Please answer each question even if you do not believe it is related to your condition. There are no wrong answers.

**1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:**

Over the last week, were you able to:	Without ANY Difficulty	SOME Difficulty	MUCH Difficulty	UNABLE To DO
Dress yourself, including tying shoelaces and doing buttons?	___0	___1	___2	___3
Get in and out of bed?	___0	___1	___2	___3
Lift a full cup or glass to your mouth?	___0	___1	___2	___3
Walk outdoors on flat ground?	___0	___1	___2	___3
Wash and dry your entire body?	___0	___1	___2	___3
Bend down to pick up clothing from the floor?	___0	___1	___2	___3
Turn regular faucets on and off?	___0	___1	___2	___3
Get in and out of a car, bus, train, or airplane?	___0	___1	___2	___3
Walk two miles or three kilometers, if you wish?	___0	___1	___2	___3
Participate in recreational activities/sports as you would like, if you wish?	___0	___1	___2	___3
Get a good night's sleep?	___0	___1.1	___2.2	___3.3
Deal with feelings of anxiety or being nervous?	___0	___1.1	___2.2	___3.3
Deal with feelings of depression or feeling blue?	___0	___1.1	___2.2	___3.3

**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	

Score:            1. FN \_\_\_\_                            2. PN \_\_\_\_                            3. PTGE \_\_\_\_                            RAPID3 \_\_\_\_