# Bay Area Arthritis and Osteoporosis

## Vipul Joshi, MD, PA

1355 Providence Road
Brandon, FL 33511

Tel: (813) 651-4441
Fax: (813) 661-3374

www.baao.org


*Welcome! Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. The information on this cover sheet answers common questions our new patients have. We hope you will find this information helpful and reassuring.*

It is **VERY IMPORTANT** that you fill out the enclosed forms before your visit and bring them with you to your appointment. We also request that you bring your **INSURANCE CARD(S)** with you for every visit. Please notify the front desk of all insurance changes and any other personal information changes before all visits so we may ensure our records are accurate. This will help avoid any insurance billing problems and difficulties in contacting you with important medical information.

If your insurance requires a **CO-PAY** for the office visit, payment is due AT THE TIME OF SERVICE. **WE ACCEPT CASH OR CHECKS ONLY.**

It is **YOUR RESPONSIBILITY** to obtain a **REFERRAL** from your primary care physician if it is required by your insurance. Please bring it with you on the day of your visit. If we do not have your referral, WE WILL NOT BE ABLE TO SEE YOU due to insurance requirements.

Any appointments broken without a **48 hour** notice may be charged a cancellation fee of $25 due to other patients needing to be seen.

Please bring a **LIST OF ALL MEDICATIONS** you are currently taking (prescription & over-the-counter) and copies of any recent medical records or lab and x-ray results you may have pertaining to your visit with us. Please do not bring x-ray or MRI films with you.

For your convenience, our facility offers multiple on site diagnostic services such as x-rays, bone density testing, ultrasounds and laboratory testing. Please plan to schedule at least 2 hours for your appointment in order to accommodate for any necessary testing at the time of your visit.

Your appointment may be scheduled with our certified, trained and experienced, Physician Assistants. However Dr. Joshi is always available for consultation with prior notification.

Please refer to our website, or call us at (813) 651- 4441 and press option 3 for detailed directions.

Thank you for your cooperation. If you have any questions or concerns, please feel free to contact our office. We look forward to seeing you soon.

Sincerely,

The Staff of
Bay Area Arthritis and Osteoporosis

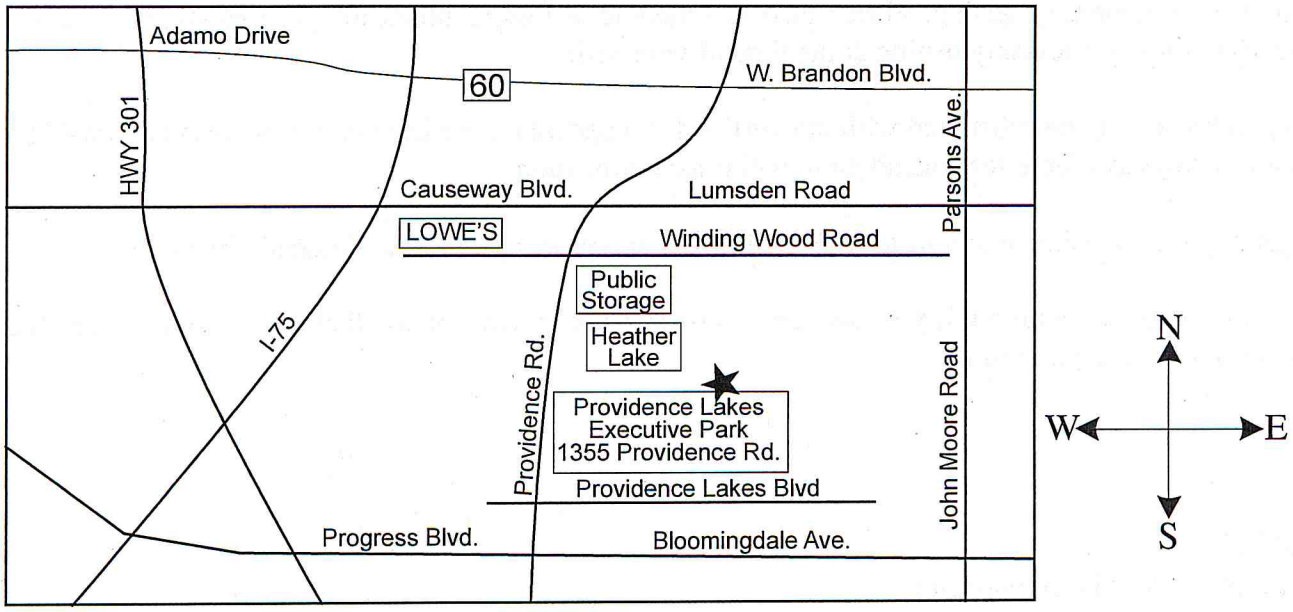
**Directions/Map:** to BAAO 1355 Providence Road Tel: 813.651.4441

**From Riverview:** Take US Hwy-301 to Bloomingdale Avenue. Head East on Bloomingdale Avenue for about 1 mile then turn left (head North) on Providence Road. Drive for about 1.5 miles. Go through the light at Providence Lakes Boulevard and make your first right into Providence Lakes Executive Park. Veer to the right as you enter and go back to the last building on your right to 1355 Providence Road.

**From Sun City Center:** Take I-75 North toward Tampa for about 13 miles. Merge on to US Hwy-301 South (exit 254) toward Riverview. Turn left (head East) on Bloomingdale Avenue and drive for about 1 mile then turn left (head North) on Providence Road and drive about 1.5 miles. Go through the light at Providence Lakes Boulevard and make your first right into Providence Lakes Executive Park. Veer to the right as you enter and go back to the last building on your right to 1355 Providence Road.

**From Plant City:** Take the JL Redman Parkway to Hwy 60/Brandon Boulevard (exit 257). Turn right on Hwy 60 (head West) for about 12 miles to Lakewood Drive. Turn left (head South) on Lakewood Drive (which becomes Providence Road). Drive for about 1 mile, passing through the light at Lumsden Road and approximately 1/2 mile down on the left (east side) of the road (after Heather Lakes), turn left into Providence Lakes Executive Park. Veer to the right as you enter and go back to the last building on your right to 1355 Providence Road.

**From Tampa:** Take the Crosstown Expressway (LeRoy Selmon Expressway) east toward Brandon for about 7 miles. Merge on to US Hwy-301 South (exit 13) and drive for about 1 mile. Turn left (head East) on Causeway Boulevard/Lumsden Road and drive for about 2 miles. Turn right (head South) on Providence Road and approximately 1/2 mile down on the left (east side) of the road (after Heather Lakes), turn left into Providence Lakes Executive Park. Veer to the right as you enter and go back to the last building on your right to 1355 Providence Road.



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**Patient Name:** _____ **Age:** _____ **DOB:** _____ **Date:** _____

**Allergies to Medication:** _____ Yes or _____ No (if yes please describe)

| Medication | Type of reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Medications you are taking:**

| Name of Medication | Dose(mg) | How many times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Personal Medical History (please mark all that apply):**

___ Rheumatiod Arthritis
___ Lupus/SLE
___ Psoriasis
___ Scleroderma/CREST
___ Polymyositis
___ Dermatomyositis
___ Sjogren's syndrome
___ Raynaud's syndrome
___ Ankylosing Spondylitis
___ Reiter's syndrome
___ Osteoarthritis
___ Osteoporosis
___ Avascular necrosis of bone
___ Fibromyalgia
___ Gout
___ Pseudogout
___ Temporal arteritis
___ Polymyalgia Rheumatica
___ Rheumatic fever
___ Wegner's Disease
___ Vasculitis _____
___ Polyarteritis nodosa/PAN
___ Childhood arthritis
___ Lyme disease
___ Uveitis (eye condition)
___ Hepatitis A/B/C
___ TB/abnormal TB skin test
___ Long term steroid use
___ Compression fracture
___ Crohn's disease
___ Ulcerative colitis
___ Cancer of _____
___ Celiac disease/Sprue
___ Seizures/Epilepsy
___ Hiatal hernia/Reflux
___ Stomach Ulcer
___ Stomach/Intestinal Bleed
___ Liver problems _____
___ Kidney problems _____
___ Lung problems _____
___ COPD
___ Asthma
___ Lung Fibrosis
___ Multiple sclerosis
___ Optic neuritis
___ Neuropathy
___ Stroke/TIA
___ Diabetes
___ High blood pressure
___ High cholesterol
___ Heart attack/angina

Reviewed By: _____

**Patient Name:** _____ **Age:** _____ **DOB:** _____ **Date:** _____

**Personal Medical History Continued (please mark all that apply):**

___ Heart failure
___ Other heart conditions
___ Glaucoma
___ Blood disorder
___ Sickle cell anemia
___ Recreational drug use
___ Rotator cuff tear
___ Paget's disease
___ Arrhythmia
___ Thyroid condition
___ Anemia
___ Leukemia/Lymphoma
___ Sexually transmitted disease
___ Prostate condition _____
___ Tendonitis/tendon tear
___ Parathyroid condition
___ Pacemaker/Difibrillator
___ Depression/anxiety
___ Low blood count _____
___ Hemophilia
___ HIV/AIDS
___ Carpal tunnel syndrome
___ Auto/other accidents
___ Sarcoidosis

Please list any other conditions: _____

_____

_____

**Surgeries:**

___ Joint Replacement
___ Tendon repair
___ Back surgery
___ Cancer surgery
___ Hysterectomy
___ Tonsillectomy
___ Leg bypass
___ Colonoscopy
___ Joint surgery
___ Arthroscopy
___ Muscle/nerve biopsy
___ Stomach surgery
___ Ovarian surgery
___ Heart bypass
___ Angioplasty of _____
___ Plastic surgery
___ Carpal tunnel repair
___ Fracture repair
___ Skin biopsy
___ Gallbladder
___ Appendix
___ Heart stent
___ Endoscopy/EGD

Please list other Surgeries: _____

_____

_____

**Family Medical History:**

___ Lupus/SLE
___ Scleroderma
___ Ankylosing Spondylitis
___ TB/tuberculosis
___ Cancer
___ Heart attack/condition
___ Rheumatoid arthritis
___ Crohn's disease
___ Paget's disease
___ Osteoporosis
___ Thyroid Condition
___ Psoriasis
___ Ulcerative colitis
___ Autoimmune conditions
___ Osteoarthritis
___ Diabetes

Please list other Family Medical: _____

_____

_____

**For Female Patients:**

___ Pregnancy loss
___ Pregnancy complications
___ Pre-eclampsia
___ Pre-term labor
___ Menstrual irregularity
Menopause at age _____
Are you planning pregnancy? Yes or No
Last menstrual cycle _____

Reviewed by: _____

**Social/Personal History:**

Smoking: ____ packs per day
____ never ____ rare ____ quit
Alcohol: _____ drinks per day
____ never ____ rare ____ quit
Recreational Drugs:
____ never ____ rare ____ quit
Occupation (present/past):

_____

Primary Doctor (name): _____

Marital: Single/Married/Divorced

**Patient Name:** _____ **Age:** _____ **DOB:** _____ **Date:** _____

As you review the following list, please check any of those problems which apply to YOU:

**General:**
___ recent weight gain ____ lbs
___ recent weight loss _____ lbs
___ fatigue/tiredness
___ fever/night sweats
___ loss of appetite
___ loss of sleep

**Muscles/Bone/Joints:**
___ difficulty getting up from chair
___ difficulty to comb hair
___ jaw hurts when chewing food
___ sore muscles
_____
___ joint pain
___ joint swelling
___ joint deformities
___ flat feet
___ morning stiffness
___ fracture of
_____

**Heart and Lungs:**
___ chest pain
___ shortness of breath
___ difficulty breathing at night
___ swelling of feet
___ irregular heart beat
___ heart murmurs
___ cough
___ coughing up blood
___ wheezing

**Stomach/Intestine/GI:**
___ nausea/vomiting
___ vomiting blood
___ heartburn
___ persistent diarrhea
___ blood in stool/black stools
___ increasing constipation
___ yellow jaundice

**Kidney/Urine/Bladder/GU:**
___ blood in urine
___ pus in urine
___ discharge from vagina/penis
___ pain/burning on urination
___ genital rash/ulcers sores

**Nervous System:**
___ headaches
___ stroke
___ seizures
___ loss of consciousness
___ loss of bladder control
___ loss of bowel control
___ tingling of hands/feet
___ pyschosis
___ memory loss

**Nose:**
___ nose bleeds
___ sores in nose
___ loss of smell

**Blood:**
___ anemia/low blood count
___ bleeding or clotting problems
___ easy bruising

**Eyes:**
___ dryness requiring eye drops
___ loss of vision
___ double/blurred vision
___ pain
___ redness
___ feels like somthing in eye

**Ears:**
___ loss of hearing
___ ringing in ears

**Mouth:**
___ dryness
___ sores in mouth
___ bleeding gums
___ sore tongue

**Throat:**
___ frequent sore throats
___ hoarseness of voice
___ difficulty swallowing

**Skin/Hair:**
___ rash/malar rash
___ photo (sun) sensitivity
___ alopecia (unusual hair loss)
___ skin tightness
___ cold related color changes of hands/feet (raynaud)
___ psoriasis

**Neck:**
___ swollen glands
___ tender glands

**Allergy/Immunology:**
___ seasonal allergies
___ immune dificienc

___ history of allergy shots
___ hives
___ urticaria

**Other Information (please write year):**
Last eye exam: _____
Last chest x-ray: _____
Last tuberculosis test: _____
Last hepatitis test: _____
Last bone density/DEXA: _____
Last colonoscopy: _____

**Female patients:**
Last mammography: _____
Last pap smear: _____

Reviewed by: _____

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## Patient Registration Form

**Patient Name:** _____ **Date of Birth:** _____

**Address:** _____ **City:** _____

**State:** _____ **Zip Code:** _____ - _____

**Alternate Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____ - _____

**Social Security Number:** _____ **Home Phone #:** _____

**Cell Phone #:** _____ **Work Phone # & extension:** _____

**Gender: Male or Female** **Race:** _____ **Ethnicity: Hispanic/Latino or Not Hispanic/Latino**

**Marital Status: Married, Single, Divorced, or Widowed**

**Referred By (doctor's name):** _____ **Primary Care Physician:** _____

**Primary Insurance Holders Information:**

**Name:** _____ **Relationship to Patient:** _____

**Social Security Number:** _____ **Date of Birth:** _____

**Secondary Insurance Holders Information:**

**Name:** _____ **Relationship to Patient:** _____

**Social Security Number:** _____ **Date of Birth:** _____

### Please Read the Following Very Carefully

**Consent for Treatment:** I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. The treatment may include but is not restricted to injectable medications, labs, x-rays, bone density tests, surgical and invasive procedures or other studies that may be helpful in the performance of the patient's care.

**Authorization for Release of Medical Records & Insurance Information:** I, herby authorize the release of any and all medical records including any financial and accounting records, including insurance information to referring physicians/primary care physicians or agencies involved in the performance of quality assurance; in the determination of benefits payable for services rendered; to process claims and/or to collect any debt.

**Assignment of Benefits and Guarantee of Account:** I realize that my insurance coverage is a contract between myself and the insurance company and that not all services may be covered benefits. By signing this agreement I am acknowledging that I am ultimately responsible for any unpaid balance on my account for services rendered. I understand that the payments of charges incurred in this office are due at the time of service. Also, this office does not bill patients for co-pays, deductibles or coinsurances. I hereby assign to Bay Area Arthritis and Osteoporosis, the medical benefits to which my dependents and/or I am entitled. I hereby agree to pay my personal balance within 30 days of receiving a statement. All unpaid balances more than 90 days past due will be processed for collections. In addition, I agree to pay any additional charges to collect my unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees. I understand the charges not covered by insurance remain my responsibility and assign insurance benefits to this clinic. Any balance sent to collections, will automatically dismiss me from the practice. If my check is returned due to Non Sufficient Funds (NSF) or "stop payment," I will incur a $30 fee. I am aware that my account will be charged $25 for any appointments I fail to keep without a 48 hour notice. By signing below, I do affirm that I have read all the above information and have answered all questions truly and to the best of my ability. I also affirm that I understand the contents of this document.

Emergency Contact Name: _____ Relationship: _____

Phone #: _____

Patient/Responsible Party Signature: _____ Date: _____

Reviewed By (staff): _____ Date: _____

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## *Your Privacy Is Important To Us*

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Policies of Bay Area Arthritis and Osteoporosis (BAAO) via their website or physical office. I hereby authorize, as indicated by my signature below, BAAO to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

It is our policy NOT TO RELEASE confidential and/or unauthorized information by telephone, answering machine, work telephone or cell phone without your permission. Whenever returning your phone calls and the answering machine picks up, information will not be left with an unauthorized person who may answer the telephone. **If you would like to have information released to someone other than you or have messages left, please complete the following:**

I authorize BAAO and its staff to leave medical information pertaining to my care by following methods and will assume responsibility to notify them whenever this information may change.

Home Ph#: _____ Call? Yes or NO Leave Message? Yes or No

Work Ph#: _____ Call? Yes or NO Leave Message? Yes or No

Cell Ph#: _____ Call? Yes or NO Leave Message? Yes or No

Please note: Other than your health insurance policy and referring doctor, we will require signed consent to release medical information.

**Please list names of people we can discuss your medical care with:**

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Print Patient Name: _____

Address: _____

Patient Signature: _____

Date: _____

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## A Message from the Staff of Bay Area Arthritis and Osteoporosis

In an effort to serve you safely and efficiently, we kindly ask for your cooperation in the following areas:

* Please bring a complete and accurate medication list (including over-the-counter medications and supplements) or all your medication bottles to **EVERY** appointment.

* We request that you obtain all medication refills at the time of your appointment.
**We will NO LONGER fill prescriptions over the phone, fax or through pharmacy request.**

* All co-pays, co-insurances and deductibles must be **paid in CASH or CHECK at the time of service.** Our office **DOES NOT** bill for these amounts. Anything over $500.00 must be in the form of a money order or a cashier's check.

* Referrals are the responsibility of the patients. Patients without a valid referral will not be seen until a valid referral has been received. When this occurs we reserve the right to charge a broken appointment fee.

* Please have all requested diagnostic testing done at least 10 days prior to your next office visit so results will be available for review. We **DO NOT** contact you with normal tests results, **ONLY** abnormalities.

* Messages will be returned within a **24 - 48 hour** period.

* Any follow-up appointments cancelled or rescheduled without a **48 hour** notice, or appointments not kept, may be charged a cancellation fee of $25.00. We have a waiting list and reserve our appointments for patients who maintain their appointments to eliminate unnecessary wait time. Also, any infusion appointments cancelled, rescheduled or not kept, without a **48 hour** notice may be charged a cancellation fee of $50.00. Our office reserves the right to **dismiss** any patient that has 3 of the above offenses within a 1 year period.

* Your follow-up appointment will be scheduled with our certified and trained Physician Assistants; however Dr. Joshi is always available for consultation with prior notification.

**Respectfully,**
**Staff of Bay Area Arthritis and Osteoporosis**

**Patient Name (print):** _____

**Patient/Responsible Party Signature:** _____

**Date:** _____

# Multi-Dimensional Health Assessment Questionnaire (MDHAQ™)(R923-NP2R)

Bay Area Arthritis and Osteoporosis 813-651-4441

**This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.**

**1. Please check (√) the ONE best answer for your abilities at this time:**

| **OVER THE PAST 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 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 |

**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. Please place a check (√) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:**

| LEFT SIDE: | None | Mild | Moderate | Severe | RIGHT SIDE: | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| a. LEFT FINGERS | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | i. RIGHT FINGERS | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| b. LEFT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | j. RIGHT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| c. LEFT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | k. RIGHT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| d. LEFT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | l. RIGHT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| e. LEFT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | m. RIGHT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| f. LEFT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | n. RIGHT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| g. LEFT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | o. RIGHT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| h. LEFT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | p. RIGHT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| q. YOUR NECK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | r. YOUR BACK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

**4. 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

**Your Name**_____ **Today's Date** _____

**PLEASE TURN TO THE NEXT PAGE**



**FOR OFFICE USE ONLY**

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

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

2. **PN** (0-10):

4. **PTGL** (0-10):

**RAPID 3™** (0-30):

**Cat:**

**HS = >12**

**MS = 6.1-12**

**LS = 3.1-6**

**R = ≤3**

**5. Please check (√) if you have experienced any of the following over the last month:**

| | | |
|---|---|---|
| __Fever | __Lump in your throat | __Paralysis of arms or legs |
| __Weight gain (>10 lbs) | __Cough | __Numbness or tingling of arms or legs |
| __Weight loss (>10 lbs) | __Shortness of breath | __Fainting spells |
| __Feeling sickly | __Wheezing | __Swelling of hands |
| __Headaches | __Pain in the chest | __Swelling of ankles |
| __Unusual fatigue | __Heart pounding (palpitations) | __Swelling in other joints |
| __Swollen glands | __Trouble swallowing | __Joint pain |
| __Loss of appetite | __Heartburn or stomach gas | __Back pain |
| __Skin rash or hives | __Stomach pain or cramps | __Neck pain |
| __Unusual bruising or bleeding | __Nausea | __Use of drugs not sold in stores |
| __Other skin problems | __Vomiting | __Smoking cigarettes |
| __Loss of hair | __Constipation | __More than 2 alcoholic drinks per day |
| __Dry eyes | __Diarrhea | __Depression - feeling blue |
| __Other eye problems | __Dark or bloody stools | __Anxiety - feeling nervous |
| __Problems with hearing | __Problems with urination | __Problems with thinking |
| __Ringing in the ears | __Gynecological (female) problems | __Problems with memory |
| __Stuffy nose | __Dizziness | __Problems with sleeping |
| __Sores in the mouth | __Losing your balance | __Sexual problems |
| __Dry mouth | __Muscle pain, aches, or cramps | __Burning in sex organs |
| __Problems with smell or taste | __Muscle weakness | __Problems with social activities |

**FOR OFFICE USE ONLY**
5. ROS: ☐

**Please check (√) here if you have had none of the above over the last month: _____.**

---

**6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes**
If "No," please go to Item 7. If "**Yes," please indicate the number of minutes_____, or hours _____** until you are as limber as you will be for the day.

**7. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.**
**M**uch **B**etter ☐ (1), **B**etter ☐ (2), the **S**ame ☐ (3), **W**orse ☐ (4), **M**uch **W**orse ☐ (5) than one week ago

**8. How often do you exercise aerobically** (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please check (✓) only one.**
☐ 3 or more times a week (3) ☐ 1-2 times per month (1)
☐ 1-2 times per week (2) ☐ Do not exercise regularly (0) ☐ Cannot exercise due to disability/ handicap (9)

**9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?**

| | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **FATIGUE IS** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **FATIGUE IS A** |
| **NO PROBLEM** | 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 | **MAJOR PROBLEM** |

**10. Over the last 6 months have you had: [Please check (√)]**

| | | | | | |
|---|---|---|---|---|---|
| ☐No | ☐Yes | An operation or new illness | ☐No | ☐Yes | Change(s) of arthritis or other medication |
| ☐No | ☐Yes | Medical emergency or stay overnight in hospital | ☐No | ☐Yes | Change(s) of address |
| ☐No | ☐Yes | A fall, broken bone, or other accident or trauma | ☐No | ☐Yes | Change(s) of marital status |
| ☐No | ☐Yes | An important new symptom or medical problem | ☐No | ☐Yes | Change job or work duties, quit work, retired |
| ☐No | ☐Yes | Side effect(s) of any medication or drug | ☐No | ☐Yes | Change of medical insurance, Medicare, etc. |
| ☐No | ☐Yes | Smoke cigarettes regularly | ☐No | ☐Yes | Change of primary care or other doctor |

**Please explain any "Yes" answer below, or indicate any other health matter that affects you:**

_____

_____

**SEX:** ☐ Female, ☐ Male **ETHNIC GROUP:** ☐ Asian, ☐ Black, ☐ Hispanic, ☐ White, ☐ Other_____

**Your Occupation** _____
**Work Status**: ☐ Full-time, ☐ Part-time, ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐Retired,
☐ Seeking work, ☐ Other_____

**Please circle the number of years of school you have completed:**
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

**Please write your weight:** _____ **pounds** or **kg** **height:** _____ **inches** or **cm**

**Your Name**_____ **Date of Birth** _____ **Today's Date** _____



**FOR OFFICE USE ONLY:** I have reviewed and recorded relevant questionnaire responses.
Date _____ Signature _____