

LA RHEUMATOLOGY MEDICAL GROUP

NEW PATIENT REGISTRATION FORM

Beverly Hills Office

Thank you for choosing LA Rheumatology Medical Group. Please complete this form before your appointment. The information you provide helps us better understand your medical history and prepare for your visit.

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Age: _____

Sex:

Male

Female

Other

Preferred Name: _____

Address:

City: _____

State: _____

Zip: _____

Cell Phone: _____

Home Phone: _____

Email Address:

Preferred method of contact:

Phone

Text

Email

EMERGENCY CONTACT

Name:

Relationship:

Phone:

PRIMARY CARE PHYSICIAN

Name:

Phone:

Referring Physician (if applicable):

INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

Medicare Number (if applicable):

PHARMACY INFORMATION

Preferred Pharmacy:

Address:

Phone:

OCCUPATION

Current Occupation:

Retired?

Yes

No

CHIEF COMPLAINT

What is the main reason for today's visit?

HISTORY OF PRESENT ILLNESS

When did your symptoms begin?

Morning stiffness:

_____ minutes

Symptoms are:

Constant

Intermittent

What makes symptoms worse?

What makes symptoms better?

PAST MEDICAL HISTORY

(Check all that apply)

Rheumatoid Arthritis

- Psoriatic Arthritis
- Lupus
- Sjögren's Syndrome
- Osteoarthritis
- Osteoporosis
- Gout
- Fibromyalgia
- Vasculitis
- Raynaud's
- Thyroid Disease
- Diabetes
- High Blood Pressure
- Heart Disease
- Stroke
- Kidney Disease
- Lung Disease
- Cancer
- Hepatitis
- Other:

PREVIOUS SURGERIES

Procedure | Year

CURRENT MEDICATIONS

(Attach medication list if needed)

Medication | Dose | Frequency

ALLERGIES

Medication | Reaction

No Known Drug Allergies

FAMILY HISTORY

Has anyone in your family had:

Rheumatoid Arthritis

Lupus

Psoriasis

Ankylosing Spondylitis

Gout

Osteoporosis

Autoimmune Disease

Other:

SOCIAL HISTORY

Marital Status

- Single
- Married
- Divorced
- Widowed

Children:

Smoking

- Never
- Former
- Current

Alcohol

- None
- Occasionally
- Daily

Exercise

- None
- 1–2 days/week
- 3–5 days/week
- Daily

REVIEW OF SYSTEMS

Please check any symptoms you currently have.

- Fever
- Weight loss
- Night sweats
- Hair loss
- Dry eyes
- Dry mouth
- Mouth ulcers
- Chest pain
- Shortness of breath
- Cough
- Heartburn
- Abdominal pain
- Blood in stool
- Joint pain
- Joint swelling
- Muscle pain
- Weakness
- Rash
- Psoriasis
- Photosensitivity
- Raynaud's

Numbness

Tingling

Depression

Anxiety

Easy bruising

None of the above

OSTEOPOROSIS SCREENING

Have you ever had a bone density (DEXA) scan?

Yes

No

Previous fracture after age 50?

Yes

No

Parent with hip fracture?

Yes

No

Currently taking calcium?

Yes

No

Vitamin D?

Yes

No

PREVIOUS RHEUMATOLOGY CARE

Previous Rheumatologist:

Previous biologic medications:

Humira

Enbrel

Orencia

Actemra

Cimzia

Simponi

Rinvoq

Xeljanz

Skyrizi

Cosentyx

Rituximab

Benlysta

Prolia

Evenity

Reclast

Other:

PATIENT GOALS

What are you hoping we can help you with today?

CONSENT

I certify that the information provided is true and complete to the best of my knowledge.

Patient Signature:

Date: