

Integrative Rheumatology
Associates, P.C.

Aly Cohen, MD, FACR

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Monroe, New Jersey 08831

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Date of first appointment: _____ / _____ / _____ Time of appointment: _____ Birthplace: _____
MONTH DAY YEAR

Name: _____ Birthdate: _____ / _____ / _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: _____ Age: _____ Sex: ☐ F ☐ M
STREET APT#

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 week _____

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: _____

Do you have an orthopedic surgeon? ☐ Yes ☐ No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____ **Example**

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:

RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

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

Other arthritis conditions: _____

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

Example:

LEFT RIGHT LEFT RIGHT

LEFT RIGHT

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.

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

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

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x-ray ____/____/____

Date of last Tuberculosis 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 eye
- ☐ 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 in 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 or coffee ground material
- ☐ Stomach pain relieved by food or milk
- ☐ 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 pass urine
- ☐ 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?
_____ Minutes _____ Hours
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle tenderness
- ☐ Joint swelling
List joints affected in the last 6 mos.

Integumentary (skin and/or breast)

- ☐ 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
- ☐ Transfusion/when _____

Allergic/Immunologic

- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection

Patient's Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?
Cups/glasses per day? _____
Do you smoke? ☐ Yes ☐ No ☐ Past – How long ago? _____
Do you drink alcohol? ☐ Yes ☐ No Number 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 *Do you snore ☐ yes ☐ no*

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

Any previous fractures? ☐ No ☐ Yes Describe: _____
Any other serious injuries? ☐ No ☐ Yes Describe: _____

FAMILY HISTORY:

IF LIVING		IF DECEASED	
Age	Health	Age at Death	Cause
Father			
Mother			

Number of siblings _____ Number living _____ Number deceased _____
Number of children _____ Number living _____ Number 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 _____	

Patient's Name _____ Date _____ Physician Initials _____
Patient History Form © 1999 American College of Rheumatology

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 breakdown ☐ Stomach ulcers ☐ Rheumatic fever
☐ Bad headaches ☐ Jaundice ☐ Colitis
☐ Kidney disease ☐ Pneumonia ☐ Psoriasis
☐ Anemia ☐ HIV/AIDS ☐ High Blood Pressure
☐ Emphysema ☐ Glaucoma ☐ Tuberculosis
Other significant illness (please list) *blood transfusion history*

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS Please review this list of "arthritis" 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. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past					
Ansaid (flurbiprofen)	Arthrotec (diclofenac + misoprostil)	Aspirin (including coated aspirin)		Celebrex (celecoxib)	Clinoril (sulindac)
Daypro (oxaprozin)	Disalcid (salsalate)	Dolobid (diflunisal)	Feldene (piroxicam)	Indocin (indomethacin)	Lodine (etodolac)
Meclomen (meclofenamate)	Motrin/Rufen (ibuprofen)	Nalfon (fenoprofen)	Naprosyn (naproxen)	Oruvail (ketoprofen)	
Tolectin (tolmetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac)		
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxychloroquine (Plaquenil)		☐	☐	☐	
Penicillamine (Cuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Etanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Prosurba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	

Patient's Name _____ Date _____ Physician Initials _____
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PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronel)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid (Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol (Zyloprim/Lopurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others					
Tamoxifen (Nolvadex)		☐	☐	☐	
Tiludronate (Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc injections		☐	☐	☐	
Herbal or Nutritional Supplements		☐	☐	☐	
Please list supplements:					

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

If yes, list:

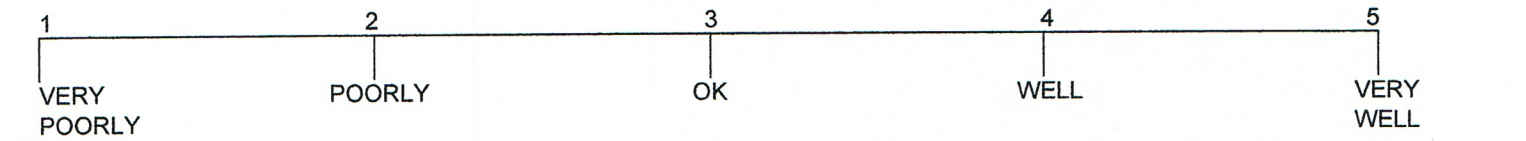
ACTIVITIES OF DAILY LIVING

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, as walker or a wheelchair? (circle one).....	☐	☐	☐
What is the hardest 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 ☐	



Integrative Rheumatology Associates PC

Aly Cohen MD, FACR

312 Applegarth Rd Suite 110

Monroe Township, NJ 08831-5347

(609) 662-5212 Fax (609) 860-5640

Date

I, _____ request and give my permission to
Print Patient's Name

release my Medical Record as indicated below from the following Medical Facility:

to **Integrative Rheumatology Associates PC** at the above address or fax number.

- ☐ Most recent lab reports AND any immune system lab reports, regardless of date
- ☐ Diagnostic Testing reports, including, but not limited to, X-Rays/MRI/CT of spine and joints
EMG reports and or last bone density report
- ☐ Progress report from patient's last visit

☐ _____

Patient's signature

Date of Birth

Witness signature

Integrative Rheumatology Associates PC

Patient Registration Form

Last Name _____ First Name _____ Male _____ Female _____
Address _____ City _____ State _____ Zip _____ - _____
Home Phone _____ Cell Phone _____ Business Phone _____
Email Address _____ Date of Birth _____ Age _____
Social Security # _____ Marital Status _____

The following questions are **required** by your insurance companies for purpose of data collection only. **Please complete:**

Race: ☐ American Indian/Alaska ☐ Asian ☐ Black ☐ Caucasian

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Decline to answer **Language spoken:** _____



Name, phone number & address of current pharmacy _____

Primary Care Physician _____

Primary Health Insurance

Secondary or Supplemental Health Insurance

Insurance Name _____

Insurance Name _____

Subscriber Name _____

Subscriber Name _____

Date of Birth _____ Relationship _____

Date of Birth _____ Relationship _____

ID# _____ Group # _____

ID# _____ Group # _____

Insurance Co Phone Number _____

Insurance Co Phone Number _____

How do you wish to be contacted? ☐ Telephone ☐ Email If by telephone may we leave messages on your answering machine? Yes No

Please provide an emergency person and telephone number we can reach on your behalf in an emergency.

Patient Signature _____

Date _____



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CONSENT TO TREAT AND RELEASE OF INFORMATION

The term "health care provider" in this document shall mean **Integrative Rheumatology Associates PC**, its agents and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as:

- Basis for planning my treatment and care.
- Information used to file my claim with the insurance company (diagnosis and procedure).
- Means by which a third-party payer can verify that billed services were actually provided.
- A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or health care providers.

I understand that I have been provided with the Notice of Privacy that provides more complete information of uses and disclosures. I further state I have been given a copy of the Notice of Privacy prior to signing this consent. I understand that **Integrative Rheumatology Associates PC** reserves the right to change their notice and practices and will provide a copy of the changed form to me prior to treatment. At that time I will be required to sign a new consent before receiving any services. I understand I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and that **Integrative Rheumatology Associates** is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that **Integrative Rheumatology Associates PC** has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment testing and procedures as are deemed necessary in the course of my care.

We will disclose your protected health information without your verbal authorization per individual circumstance, only with your written authorization which you may fill in below.

I authorize the release of my protected health information with regard to the minimum necessary policy, to the following individual(s):

Relationship _____

Relationship _____

RELEASE OF INFORMATION

Information about necessary to substantiate my insurance claims may be released by the health care provider in my care.

FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health providers are not paid after reasonable notice, that account shall be deemed delinquent and a service can be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

Signature of patient or responsible party Date _____

Print name of signature above (specify relationship if not patient)

Witness _____ Title _____ Date _____

OSTEOPOROSIS QUESTIONNAIRE

Today's Date: _____

Name: _____ Referring Physician: _____

Age: _____ SS#: _____ Race: _____

Height: _____ Weight: _____ DOB: _____ Zip Code: _____

Ethnicity: _____ African-American _____ Caucasian _____ Asian _____ Hispanic

Have you previously had DEXA (bone density)? _____ YES _____ NO

WHERE? _____ WHEN? _____

Are you on hormone replacements (Estrogen)? _____ Duration? _____

Age of menopause? _____ Have you had ovaries removed? _____ Age _____

Have you taken any of the following medications?

_____ Steroids: Dose _____ Duration _____ When: _____

_____ Heparin

_____ Antiseizure Drugs

_____ Thyroid Replacement

Are you on Osteoporosis medication? _____ YES _____ NO

_____ : Miacalcin _____ : Fosamax _____ : Estrogens _____ : Evista

_____ : Actonel _____ : Forteo _____ : Boniva _____ : Reclast

Do you have a history of: _____ Hyperthyroidism _____ Hyperparathyroidism

_____ Cushing's Disease _____ Eating Disorder _____ Ulcer Disease _____ *celiac disease*

Have you had any bone fractures in the past? _____ YES _____ NO When: _____

Have you had surgery in this year? _____ YES _____ NO What Type: _____

Do you smoke? _____ YES _____ NO Number of cigarettes/day _____

Do you drink alcohol? _____ YES _____ NO Number of drinks/day _____

Do you drink soda? _____ YES _____ NO Number of sodas/day _____

Do you have a diet LOW in calcium?

Do you take calcium supplements?

Do you have an INACTIVE lifestyle? _____ Do you exercise? _____

Please list activities and frequencies:

Do you have a family history of Osteoporosis?

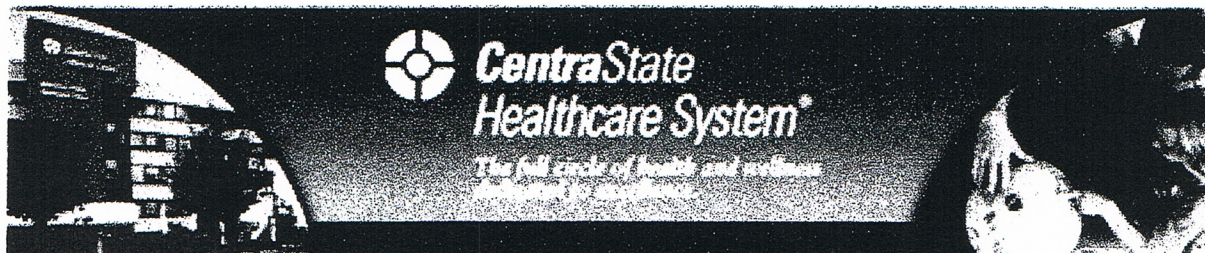
Have you had a previous fracture? _____ Where? _____

Have you had spine or hip surgery? _____ What type? _____

Have you noticed a decrease in your height? _____ How much? _____

My results should be sent to a Doctor (address):

* Please specify one doctor only. If that doctor referred you here for the bone density, you must call that office to request a copy if you want it to be sent to a second physician.



The Medical Offices at Monroe

Renaissance Crossings
312 Applegarth Road
Monroe, NJ 08831

From the New Jersey Turnpike / Exit 8A

Pay toll and keep left at the fork,
Follow signs for Monroe/State Hwy 32 E/Jamesburg
Merge onto Forsgate Dr./RT-32
Continue to follow Forsgate Dr.
Turn right at Applegarth Rd
Destination will be on the right.

From the Garden State Parkway / Exit 100B

Take exit 100B toward Freehold/State Hwy 33
Continue to follow RT-33 (18.7 miles)
Turn right at Applegarth Rd.
Destination will be on the left.

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