COLORADO ARTHRITIS
ASSOCIATES

STUART S. KASSAN, MD, FACP, MACR
A PROFESSIONAL CORPORATION
CERTIFIED BY THE AMERICAN BOARD OF INTERNAL MEDICINE AND RHEUMATOLOGY
HEATHER FINLAYSON, MS, PA-C
MARY STULTS, MS, PA-C

Dear New Patient,

If you are scheduled to see Dr. Kassan:

Please be advised that it is not uncommon for his wait time to exceed two hours. Dr. Kassan typically spends 30-60 minutes with new patients. We offer pagers that allow you to travel up to 1 mile away so that you may run an errand or get a bite to eat while you are waiting to see the doctor. You may also call ahead of your appointment time so that we can help you adjust your arrival time accordingly. Please note, although we do our best to estimate when he will see you, his wait times can fluctuate. Unfortunately we cannot predict how long he will spend with the patients before you, we will do our best to minimize your wait time. Thank you for your patience.

If you are scheduled to see Heather or Mary:

Mary and Heather do tend to run on time so we do ask that you arrive at your scheduled time. If you are more than 10 minutes late for your appointment, you may be asked to reschedule.

Insurance

We accept most major private insurance including Anthem/BCBS, United Healthcare, Humana, Bright Health, and Rocky Mountain Health Plan, and Cigna. However, we may be out of network for some of the individual plans listed above. Please check with your insurance to make sure Dr. Kassan is in network prior to your appointment.

Medicare

We do accept Medicare patients if they have a secondary

insurance only.

Medicaid

We only accept Medicaid as a secondary insurance.

198 UNION BLVD., SUITE 150 • LAKEWOOD, COLORADO 80228
TELEPHONE 303-892-6033 • FAX 303-573-6929

ICAMRL
Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories
Accredited Magnetic Resonance Facility

Tricare

We only accept Tricare as a secondary. We do not take Tricare Prime.

Work Comp

We do not see work comp cases.

Referrals

Some plans require that you obtain a referral from your primary care physician. Please note that if your plan requires a referral for your visit, and you do not have one, you will be asked to reschedule. It is the patient's responsibility to obtain the referral from their PCP. It is best to hand carry the referral with you to your visit to make sure it is in place at your appointment time. Referrals are typically only good for 6 visits or 6 months. Please keep track of when your referral expires so that you can contact your PCP for a new one prior to the expiration date.

Medical Records

It is important that we have as much information as possible about your medical history. Please bring a list of all medications including dosage. We recommend that you carry with you any recent blood work, records from other physicians, x-rays, or reports from other imaging with you to your appointment. We will also need your insurance card(s) and a photo ID.

I have read the above information.

X_____Date_____

_____

Printed Name

RHEUMATOLOGY PATIENT QUESTIONNAIRE

Date of First Appointment: ____/____/____ Birthplace:_____

Name: _____ Birth Date: ____/____/____
Last First Middle Initial Maiden

Address: _____ Age:_____ Sex: ___F ___M
Street Apt. No.

_____Telephone: Home:(_____)_____
City State Zip Work: (_____)_____
Cell: (_____)_____

Referred By: (Check One)

_____Self _____Family _____Friend _____Doctor _____Other Health Professional

Name of Person Making Referral: _____

Name of Physician Providing Your General Medical Care (Your PCP)? _____

Do You Have An Orthopedic Surgeon?_____ If Yes, Name_____

Describe Briefly Your Present Symptoms: _____

_____

When Symptoms Began (Approximate):_____ Diagnosis Given? _____

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)

Yourself	Relative Name / Relationship	Yourself	Relative Name / Relationship
_____ Arthritis (type unknown)	_____	_____ Lupus or SLE	_____
_____ Osteoarthritis	_____	_____ AnkylosingSpondylitis	_____
_____ Rheumatoid Arthritis	_____	_____ Childhood Arthritis	_____
_____ Gout	_____	_____ Osteoporosis	_____

Other Arthritis Conditions: _____

_____

How much pain have you had because of your condition **IN THE PAST WEEK?**
(Place a mark on the line below to indicate):

NO PAIN |_____| **PAIN AS BAD AS COULD BE**

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK
(Place a mark on the line below to indicate):

FATIGUE IS NO PROBLEM |_____| **FATIGUE IS MAJOR PROBLEM**

PAST PERSONAL HISTORY

Childhood Diseases (Check If You Have Had):

_____Chicken Pox _____Mumps

_____ Measles _____Strep Throat

_____ German Measles

Other Please List: _____

Environmental Exposures (Check and List All That Apply To You):

_____Toxins, solvents/other: _____

_____ Animal / Pet Contact: _____

_____ Foreign Travel: _____

_____ Camping / Tick Exposure: _____

_____ Blood Transfusions (When): _____

Health Maintenance:

List Year When You Last Had The Following:

Immunizations: Flu _____ Pneumococal _____ Tetanus _____ Other _____

Rectal Exam _____ PAP Smear _____

Stool Exam For Blood _____ Flexible Sigmoidoscopy_____

Breast Exam_____ Cholesterol _____ Colonoscopy _____

Mammogram _____ Prostate Cancer Blood Test_____

PAST PERSONAL HISTORY (Continued):

Do You, Or Have You 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 _____ Kidney Stones _____

Allergies / Asthma _____ Eczema / Hay Fever _____

Other Significant Illness (Please List): _____

_____

Previous Operations / Hospitalizations:

Type / Problem	Year	Surgeon / Physician	City

Any Previous Fractures? _____N _____Y Describe: _____

_____

Any Other Serious Injuries? _____ N _____Y Describe: _____

_____

DRUG ALLERGIES / ADVERSE REACTIONS:

Have You Had Any Drug Allergies / Reactions? _____ N _____ Y

To What? _____

Describe Reaction: _____

SYSTEMS REVIEW

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

GENERAL
_____ Recent weight gain / amount
_____ Recent weight loss / amount
_____ Fatigue
_____ Weakness
_____ Fever

NERVOUS SYSTEM
_____ Headaches
_____ Dizziness
_____ Fainting
_____ Muscle spasm
_____ Loss of consciousness
_____ Sensitivity or pain of hands and/or feet
_____ Memory loss

EARS
_____ Ringing in ears
_____ Loss of hearing

EYES
_____ Pain
_____ Redness
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ Feels like something in eye

NOSE
_____ Nosebleeds
_____ Loss of smell
_____ Dryness

MOUTH
_____ Sore tongue
_____ Bleeding gums
_____ Sores in mouth
_____ Loss of taste
_____ Dryness

THROAT
_____ Frequent sore throats
_____ Hoarseness
_____ Difficulty in swallowing

NECK
_____ Swollen glands
_____ Tender glands

HEART AND LUNGS
_____ Pain in chest
_____ Irregular heart beat
_____ Sudden changes in breathing at night
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ High blood pressure
_____ Heart murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ Night sweats

STOMACH AND INTESTINES
_____ Nausea
_____ Vomiting of blood or coffee ground material
_____ Stomach pain relieved by food or milk
_____ Yellow Jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Black stools
_____ Heartburn

KIDNEY/URINE/BLADDER
_____ Difficult urination
_____ Pain or burning on urination
_____ Blood in urine
_____ Cloudy/Smoky urine
_____ Pus in urine
_____ Discharge from penis/ vagina
_____ Frequent urination
_____ Waking up at night to urinate
_____ Vaginal dryness
_____ Sexual difficulties
_____ Prostate trouble

SKIN
_____ Easy bruising
_____ Redness
_____ Rash
_____ Hives
_____ Sun sensitive
_____ Tightness
_____ Nodules/Bumps
_____ Hair loss
_____ Color changes of hands or feet in the cold

MUSCLES/JOINTS/BONES
_____ Morning stiffness
Lasting how long:
_____ Minutes
_____ Hours
_____ Joint pain
_____ Muscle weakness
_____ Muscle tenderness
_____ Joint swelling
List joints afftected in last 6 mos.
_____
_____
_____
_____
_____
_____

OTHER
_____ Numbness
_____ Seizures
_____ Depression
_____ Suicide attempt
_____ Sinusitus
_____ Blood clots
_____ Miscarriages
_____ Snoring
_____ Muscle cramps
_____ Legs jump at night
_____ Cold intolerance
_____ Breast lump/ discharge

BLOOD
_____ Anemia
_____ Bleeding tendency

Date of last eye examination_____
Date of last chest x-ray _____
Date of last Tuberculosis test _____

MENSTRUAL
Age when periods began_____ Periods regular____Y_____N How many days apart_____
Date of last period_____ Date of last Pap Smear_____ Bleeding after menopause____Y _____N

FAMILY HISTORY

If Living **If Deceased**

Father: Age _____ Health _____ Age at Death_____ Cause_____

Mother: Age _____ Health _____ Age at Death_____ Cause_____

Number of Brothers _____ Number Living _____ Number Deceased _____

Number of Sisters _____ Number Living _____ Number Deceased _____

Number of Children ____ Number Living ____ Number Deceased ____ List Ages of Each_____

Serious Illnesses of Children_____

_____

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

Cancer_____ Heart Problems_____ Asthma_____ Goiter_____

Leukemia_____ Stroke_____ Cataracts_____ Diabetes_____

Epilepsy_____High Blood Pressure_____ Bleeding Tendency_____ Rheumatic Fever_____

Migraine_____ Colitis_____ Kidney Disease_____ Pneumonia_____

Psoriasis_____ Alcoholism_____ Emphysema_____ Allergies/Asthma_____

Mental Illness_____

MARITAL STATUS

_____ Never Married _____ Married _____ Divorced _____Separated

Spouse: _____Alive / Age _____ _____Deceased / Age _____ Major Illnesses_____

EDUCATION (Circle Highest Level Attended)

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

Occupation_____

Average Number Of Hours Worked Per Week_____

SOCIAL HABITS:

Do you drink coffee? _____
Cups per day? _____
Do you smoke? _____
Cigarettes per day? _____
Has anyone ever told you to cut down on your drinking?_____
Do you use drugs for reasons that are not medical? If so, please list:
_____
_____
How many pillows do you sleep on each night? _____
Do you get enough sleep at night?
_____Yes _____No
Do you wake up feeling rested?
_____Yes _____No

Diet:
Special diet_____
Dairyproducts _____
Health foods _____
Is your appetite good? _____

Exercise:
What do you do for exercise each week? _____
_____

Leisure:
Hobbies:_____
Other: _____

PERSONAL BELIEFS, COPING, AND LIFE STRESS SCALES:

Chose the best answer for how you felt over the past week	***Please Circle One***	
Are you basically satisfied with your life?	Yes	No
Have you dropped many of your activities and interests?	Yes	No
Do you feel your life is empty?	Yes	No
Do you often get bored?	Yes	No
Are you in good spirits most of the time?	Yes	No
Are you afraid that something bad is going to happen to you?	Yes	No
Do you feel happy most of the time?	Yes	No
Do you often feel helpless?	Yes	No
Do you prefer staying at home to going out and doing new things?	Yes	No
Do you feel you have more problems with memory than most people?	Yes	No
Do you think it is wonderful to be alive now?	Yes	No
Do you feel pretty worthless the way you are now?	Yes	No
Do you feel full of energy?	Yes	No
Do you feel that your situation is hopeless?	Yes	No
Do you think that most people are better off than you are?	Yes	No
Do you have difficulty concentrating or making decisions?	Yes	No
Do you have problems thinking clearly?	Yes	No
Do you get upset or agitated easily?	Yes	No
Do you find it difficult to find the correct word?	Yes	No
Have you had more problems with depression or thoughts of death recently?	Yes	No
Do you feel in control of your life with respect to decision making, daily activity and routines, and responding to the needs and requests of others?	Yes	No
Do you feel you have ever suffered mental, physical, or sexual abuse during your life?	Yes	No
Do you have any significant personal, family, or job-related stresses that you have recently or are presently having to deal with?	Yes	No

HOME CONDITIONS:

_____House _____Apartment

Do you have to climb stairs? _____Y _____N If yes, how many?_____

Number of people in household? _____ Relationship and age of each _____

Who does most of the housework? _____

Who does most of the shopping? _____

On the scale below, circle a number that best describes the situation. **MOST OF THE TIME I FUNCTION....**

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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, pencil, etc.)	_____	_____	_____
Walking?	_____	_____	_____
Climbing stairs?	_____	_____	_____
Descending stairs?	_____	_____	_____
Sitting down?	_____	_____	_____
Getting up from chair?	_____	_____	_____
Touching 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 other family members?	_____	_____	_____
In your sexual relationship?	_____	_____	_____
Engaging in leisure time activities?	_____	_____	_____
With morning stiffness?	_____	_____	_____
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)	_____	_____	_____

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

MEDICATIONS:

Present: (List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name Of Drug	Dose	How Long Have You Taken Medication?	Does It Help? (A lot, a little, not at all)

Past: 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	Results			Reactions
		A Lot	Some	Not At All	
1. Aspirin					
2. Aspirin-containing product					
3. Lodine					
4. Disalcid					
5. Tylenol (Plain)					
6. Tylenol with codeine					
7. Darvon/Darvocet					
8. Clinoril/Sulindac					
9. Feldene					
10. Indocin					
11. Meclomen					
12. Motrin					
13. Nalfon					
14. Naprosyn/Naproxen					
15. Tolectin					
16. Cortisone/Predisone					
17. Relafen					
18. Colchicine					
19. Zyloprim/Allopurinol					
20. Gold (shots or pills)					
21. Plaquenil					
22. Penicilamine					
23. Methotrexate					
24. Imuran					
25. Cytoxen					
26. Bextra					
27. Mobic					
28. Celebrex					
29. Vioxx					
30. Didronel					
31. Miacalcin					
32. Fosamax					
33. Actenol					
34. Humira					
35. Enbrel					
36. Remicade					
37. Other					
38. Other					
39. Other					