SANTA FE RHEUMATOLOGY

404 Brunn School Road Suite A
Santa Fe, NM 87505

INSTRUCTIONS

Please complete this form, then print, and bring it with you to your appointment.

Name (as it appears on your insurance card):_____

Date of Birth:_____

Address:_____

Phone Number:_____ Alternate Phone:_____

Emergency Contact Name and Phone Number:_____

Relationship to Emergency Contact: _____Marital Status:_____

Primary Insurance:_____ Policy Holder's Name and D.O.B:_____

ID#:_____Group #:_____

Secondary Insurance:_____ Policy Holder's Name and D.O.B:_____

ID#:_____Group#:_____

Pharmacy Benefit Company:_____

Local Pharmacy and Location:_____

Local Lab and Location:_____

Email Address:_____

Were You Referred By A Friend Or Family Member? _____If So, Who Referred you?_____

Name: _____

Date of Birth: _____

Drug Allergies:_____ No_____ Yes

Name of drug and reaction (i.e. hives, swelling) _____

_____

Primary Care Provider:_____

Other Physicians: _____

MEDICATIONS

List medications and supplements with dosages: (i.e. Aspirin 81 mg, once daily)

DO YOU HAVE OR HAVE YOU EVER HAD

Anemia_____

Ankylosing Spondylitis_____

Anxiety_____

Arthritis_____

Asthma_____

Bleeding Disorder_____

Blood Clots_____

Cancer_____

Cataracts_____

Connective Tissue Problem _____

COPD_____

CREST_____

Crohn's _____

Depression_____

Diabetes_____

Fibromyalgia_____

GERD/Acid Reflux_____

Giant Cell Arteritis _____

Gout_____

Heart Attack_____

Heart Disease_____

High Cholesterol_____

High Blood Pressure_____

HIV/AIDS_____

Kidney Disease_____

Kidney Stones_____

Liver Disease_____

Lung Disease_____

Lupus_____

Migraines _____

Osteoporosis_____

Peripheral Vascular Disease_____

Polymyalgia Rheumatica _____

Psoriasis_____

Psoriatic Arthritis_____

Raynaud's_____

Rheumatoid Arthritis_____

Scleroderma_____

Sjogren's _____

Wegener's _____

Vasculitis_____

Other Significant Medical Problems:

_____

_____

_____

SURGERIES: **DATES:**

Family History:

Have any of your family members had the following: (Please list members as maternal or paternal and specify if more than one sibling.)

Rheumatoid Arthritis_____ Diabetes_____

Lupus_____ Heart Disease_____

Ankylosing Spondylitis_____ Cancer_____

Gout_____Bleeding Disorder_____

Social History:

Occupation:_____

Do you exercise regularly? No____ Occasional____ Moderate____ Heavy____

If yes, what do you do for exercise _____

Smoking: Never smoked____ Former smoker ____ Tobacco years of use____

Current smoker _____ How much daily_____

Alcohol Intake: None____ Occasional ____ Moderate ____ Heavy ____

VACCINES:

Have you had the flu vaccine this season? Yes_____ No_____

Have you had the pneumonia vaccine? Yes___ No ___Have you had the shingles vaccine? Yes_____ No _____

Have you had a TB test? Yes __ No __ Approximate date: _____ positive/negative: _____