Patient Registration Sheet
Idaho Falls Arthritis Clinic, PC
Office of
Craig D. Scoville, M.D., Ph.D.

Thank you for selecting our office for your rheumatologic care. We are looking forward to serving you.

We have you scheduled for _____@_____ for a new patient evaluation. Please fill out the enclosed forms.

Name: _____
Last First Middle

Demographics
Race (*Please circle at least one*):

American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander Other Race Patient Declined White

Ethnicity (*Please circle at least one*):

Hispanic, Latino, or Spanish Origin Non-Hispanic, Latino, or Spanish Origin Patient Declined

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Birthdate: _____ Social Security #: _____ Spouse's Birth Date: _____

Sex: _____ Marital Status: Single _____ Married: _____ Employer: _____

Parent/Spouse: _____ Social Security #: _____

Parent/Spouse Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Referring Physician's Name: _____ Family Physician: _____

Primary Insurance Company: _____

_____
Policy Holder's Name SSN # Birthdate Relationship

Secondary Insurance Company: _____

_____
Policy Holder's Name SSN # Birthdate Relationship

Patient Information Sheet

Name: _____ DOB: _____ Age: _____

What questions/problems brought you in to see a rheumatologist? _____

_____

1. **Current medications list** (Please list **ALL** medications and dosages, ***INCLUDING*** vitamins, aspirin, etc.):

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. **Allergies to medications** (List all negative drug reactions):

_____
_____
_____

3. **Past medical history** (Hospitalization, operations, significant injuries/accidents) Please include dates:

_____
_____
_____

4. **Please check if you have or have had the following**:
   High blood pressure:____ Gout:____ Cancer:____ Thyroid problems:____ Rheumatic heart disease:____

5. **Family History** (Please check if a family member has or had one of the following):

	Father	Mother	Brother	Sister	Grandfather	(P)	(M)	Grandmother	(P)	(M)
Arthritis	_____	_____	_____	_____		_____	_____		_____	_____
Cancer	_____	_____	_____	_____		_____	_____		_____	_____
Gout	_____	_____	_____	_____		_____	_____		_____	_____
Diabetes	_____	_____	_____	_____		_____	_____		_____	_____
Thyroid disease	_____	_____	_____	_____		_____	_____		_____	_____
Psoriasis	_____	_____	_____	_____		_____	_____		_____	_____

6. **Habits**:
   Do you smoke/vape/chew? NO:____ YES:____
   Do you drink alcoholic beverages?
   NO:___ YES:___ if so how, how often? Daily:___ 1-2 per month:___ 1-2 per year:___

7. **Social/Functional History**:
   List who lives with you at home (Family, pets):_____

   _____

   Your occupation(s):_____

Name:_____ Date:_____

General Health:

	Yes	No
Weight Gain		
Weight Loss		
Fever		
Fatigue		
Chills		
Night Sweats		
Hot Flashes		

Ears, Nose, Mouth, Throat:

	Yes	No
Ear Pain		
Nosebleeds		
Hearing Loss		
Hoarseness		
Ringing in Ears		
Sore Throat		
Mouth Sores		
Drainage		
Congestion		
Difficulty Swallowing		
Dental Pain		

Respiratory/Lungs:

	Yes	No
Shortness of Breath		
Asthma		
Sleep Apnea		
Productive Cough		
Non-Productive Cough		
Wheezing		
Blue Discoloration of Skin		
Snoring		
Daytime Drowsiness		

Eyes:

	Yes	No
Eye Pain		
Vision Disturbance		
Dry Eyes		
Watery Eyes		
Eye Swelling		
Itchy Eyes		

Musculoskeletal:

	Yes	No
Back Pain		
Neck Pain		
Joint Swelling/Stiffness/Pain		
Extremity Pain		
Decreased Range of Motion		
Muscle Aches		
Unable to Bear Weight		
Muscle Spasms/Cramps		

Neurological:

	Yes	No
Numbness or Tingling		
Headaches		
Loss of Balance		
Trouble with Speech		
Forgetfulness or Confusion		
Fainting		
Weakness		
Dizziness		
Loss of Consciousness		
Tremors		
Seizures		
Double Vision		

Cardiovascular:

	Yes	No
Chest Pain/Tightness		
Rapid Heartbeat		
Palpitations		
Varicose Veins		
Swelling in Legs/Feet/Ankles		
Painful Breathing While Laying Flat		

GI:

	Yes	No
Black or Bloody Stools		
Abdominal Pain		
Nausea/Vomiting		
Heartburn/Acid		
Constipation		
Loss of Appetite		
Use of Laxatives		
Cramping		
Diarrhea		

GU:

	Yes	No
Frequent Urination		
Urinary Urgency		
Frequent Nighttime Urination		
Painful Urination		
Blood in Urine		
Testicular Pain		
Pelvic Pain		
Abnormal Urine Smell or Color		
Abnormal Menstruation		
Burning		
Menopause		
Pain During Intercourse		
Weak Urinary Stream		
Urinary Retention		
Protein in Urine		
Incontinence		

Integumentary:

	Yes	No
Rash		
Change in Skin Color		
Itching		
Lesions		
Breast Pain, Lump, or Discharge		
Changes in Moles		
Dry Skin/Nails		

Psych/Social

	Yes	No
Hallucinations		
Behavioral Changes		
Depression		
Suicidal Ideations		
Self-Harm		

Hematological/Lymph:

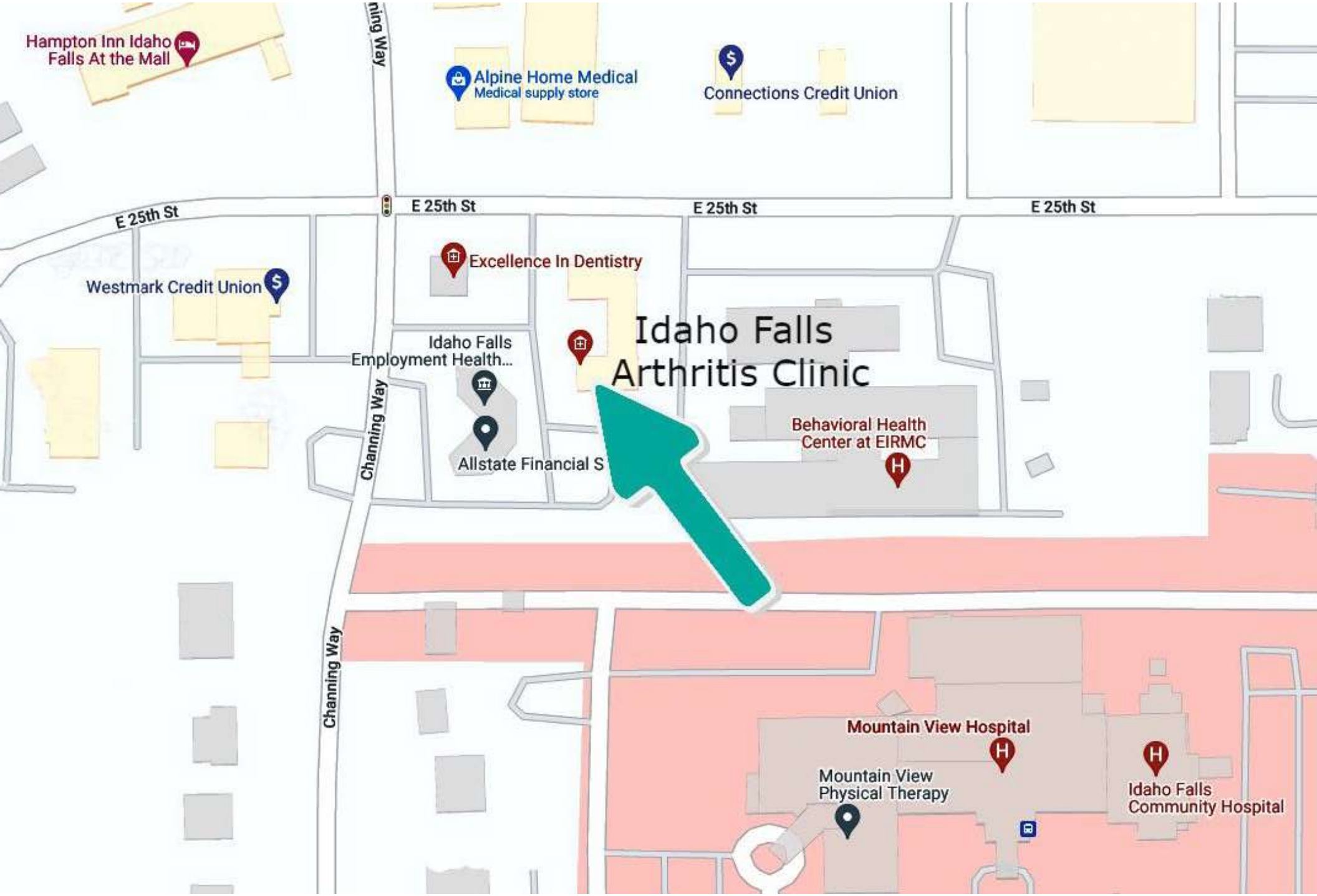
	Yes	No
Bleeding Easily		
Swollen Glands		
Delayed Healing		
Bruising		

Endocrine:

	Yes	No
Decreased Appetite		
Increased Appetite		
Heat/Cold Intolerance		
Increased Thirst		
Increased Sweating		

Allergy/Immunologic:

	Yes	No
Food Allergy		
Environmental Allergy		
Medication Allergy		
Hay Fever		
Hives		
Immune Disorders		


Hampton Inn Idaho Falls At the Mall
Alpine Home Medical
Medical supply store
Connections Credit Union
E 25th St
E 25th St
E 25th St
E 25th St
Excellence In Dentistry
Westmark Credit Union
Idaho Falls Arthritis Clinic
Idaho Falls Employment Health...
Channing Way
Allstate Financial S
Behavioral Health Center at EIRMC
Channing Way
Mountain View Hospital
Mountain View Physical Therapy
Idaho Falls Community Hospital