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

IDAHO FALLS ARTHRITIS CLINIC
an Affiliate of Mountain View Hospital

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		

Patient Health Questionnaire

How often have you experienced one of the following symptoms over the past two weeks? Please check the option that best describes you.

Little interest or pleasure in daily activities within the last 2 weeks?

	No - Not at all
	Yes - More than half the day(s)
	Yes - Several days
	Yes - Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks?

	No - Not at all
	Yes - More than half the day(s)
	Yes - Several days
	Yes - Nearly every day

If you have answered "Yes" to either of the above questions, please answer the following questions:

Difficulty falling or staying asleep:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Feeling bad or down about yourself:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Feeling tired or little to no energy:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Trouble concentrating:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Poor appetite or overeating:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Moving or speaking slowly:

	Not at all
	More than half the day(s)
	Several days
	Nearly every day

Patient Medical Summary

Please answer the following questions related to your medical history.

Do you have an Advance Directive?

	No
	Yes
	Declined to respond

If so, what type of Advance Directive do you have?

	Living will
	Medical durable power of attorney
	Other

Please list any *new* medical procedures:

_____

_____

Do you smoke?

	Never (less than 100 times in lifetime)
	4 or less cigarettes (less than 1/4 pack)
	5-9 cigarettes (between 1/4 to 1/2 pack)
	10 or more cigarettes (1/2 pack or more)
	Decline tobacco questionnaire
	Other:

Please include a current medication and allergy list when returning your paperwork to the receptionist. If you do not have one, please let the receptionist know. Thank you!

Functional Assessment

Please answer the following questions concerning mobility and function.

When you wake up in the morning do you feel stiff and/or sore?

	No
	Yes
	Most of the time
	Some of the time

O Stiff O Sore O Both

If yes, about how long does it take until you start feeling better?

	10-15 Minutes
	30 Minutes
	45 Minutes
	60 Minutes
	1-2 Hours
	Longer than 2 Hours

Please select the general locations you experience the majority of your pain:

	Head (Headaches/Migraines)		Wrist(s)		Hip(s)/Pelvic Region
	Neck		Hand(s)		Upper Leg(s)
	Shoulder(s)		Chest		Lower Leg(s)
	Upper Arm(s)		Torso		Knee(s)
	Lower Arm(s)		Upper Back		Ankle(s)
	Elbow(s)		Lower Back		Feet

On a scale of 0-10 with ten being unbearable pain, what is the average of your pain in the past 24-48 hours? Please circle the best choice that describes your pain.

0-No Pain 1 2 3 4 5 6 7 8 9 10-Worst

Have you had any bad reactions to any of your current medications since your last visit?

	Yes
	No

Do you feel rested in the morning?

	Yes
	No

Have you had any rashes or mouth sores in the last 30 days?

	Yes
	No
	Mouth sores
	Rash

If no, how many times do you wake from your sleep due to pain?

	1		2 times		More than 3 times
	1-2 times		2-3 times		

When was your last eye exam?	Month:	Year:

Immunization History

COVID 19 Vaccine Status:

	Not Received
	Pfizer Vaccine
	Moderna Vaccine
	Johnson & Johnson Vaccine
	Other

Number of COVID Vaccine Doses:

	1 Dose
	2 Doses
	3 Doses
	Greater Than 3 Doses

Have you received an influenza vaccine this flu season?

	Yes
	No, but plan to get one
	No, do not plan to get one
	Unknown

If you do not plan to get a flu shot, why not?

	Allergy/Sensitivity to Flu Shot
	Allergy to Egg
	Allergy to Latex
	Bone Marrow Transplant in last 6 months
	Guillan-Barre Syndrome in the last 6 months
	Patient/Family Refusal, Personal Preference
	Vaccine Not Available
	Physician Recommendation

If you are OVER THE AGE OF 65 OR UNDER THE AGE OF 18, have you received a Pneumonia Vaccine?

	Yes, within the past 5 years
	Yes, more than 5 years ago
	Never Received
	Unknown

If OVER THE AGE OF 65 OR UNDER THE AGE OF 18 and have never received Pneumonia Vaccine, why not?

	Bone marrow transplant within the last 12 months
	Chemotherapy within the past 2 weeks
	Currently on scheduled course of chemotherapy
	Currently on scheduled course of radiation
	Radiation within the past 2 weeks
	Other vaccine received in the last 8 weeks
	Shingles vaccine in the past 4 weeks
	Patient/Family Refusal, Personal Preference
	Vaccine Not Available
	Physician Recommendation

For Patients <u>over 65</u>, please answer the following questions

Please selected the option that best describes you.

If any, how many falls have you experienced within the last year?

	None
	One **without** injury
	One **with** injury
	Two or more falls **without** injury
	Two or more falls **with** injury

Do you feel unsteady when standing or walking?

	No
	Yes

Do you have a fear of falling?

	No
	Yes

IDAHO FALLS
ARTHRITIS CLINIC

• MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY •

Thank you for trusting your medical care to Idaho Falls Arthritis Clinic, an affiliate of Mountain View Hospital. Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to do better utilize available appointments for our patients in need of medical care.

When you schedule an appointment with Mountain View Hospital or any of its affiliated locations we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will noted as a "no show" occurrence.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be noted as a "no show" occurrence.
- **If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient will be dismissed from Idaho Falls Arthritis Clinic.**

As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A "no show" is someone who misses an appointment without canceling it within a 24 hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

Delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is 15 minutes past their appointment time, we may have to reschedule your appointment. **You may contact us during our business hours or leave a message at: 208-542-9080**
I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Patient Name:_____ **Relationship:**_____

Patient Signature:_____ **Date:**_____

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ARTHRITIS CLINIC
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my "Protected Health Information (PHI)", under a federal health privacy law. I understand that any information obtain by the requesting clinic may and will be used to conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

I hereby authorize the use and disclosure of my Personal Health Information (PHI) as indicated or described below:

- ○ All health information relating to me
- ○ Only the following specific information:

_____

_____

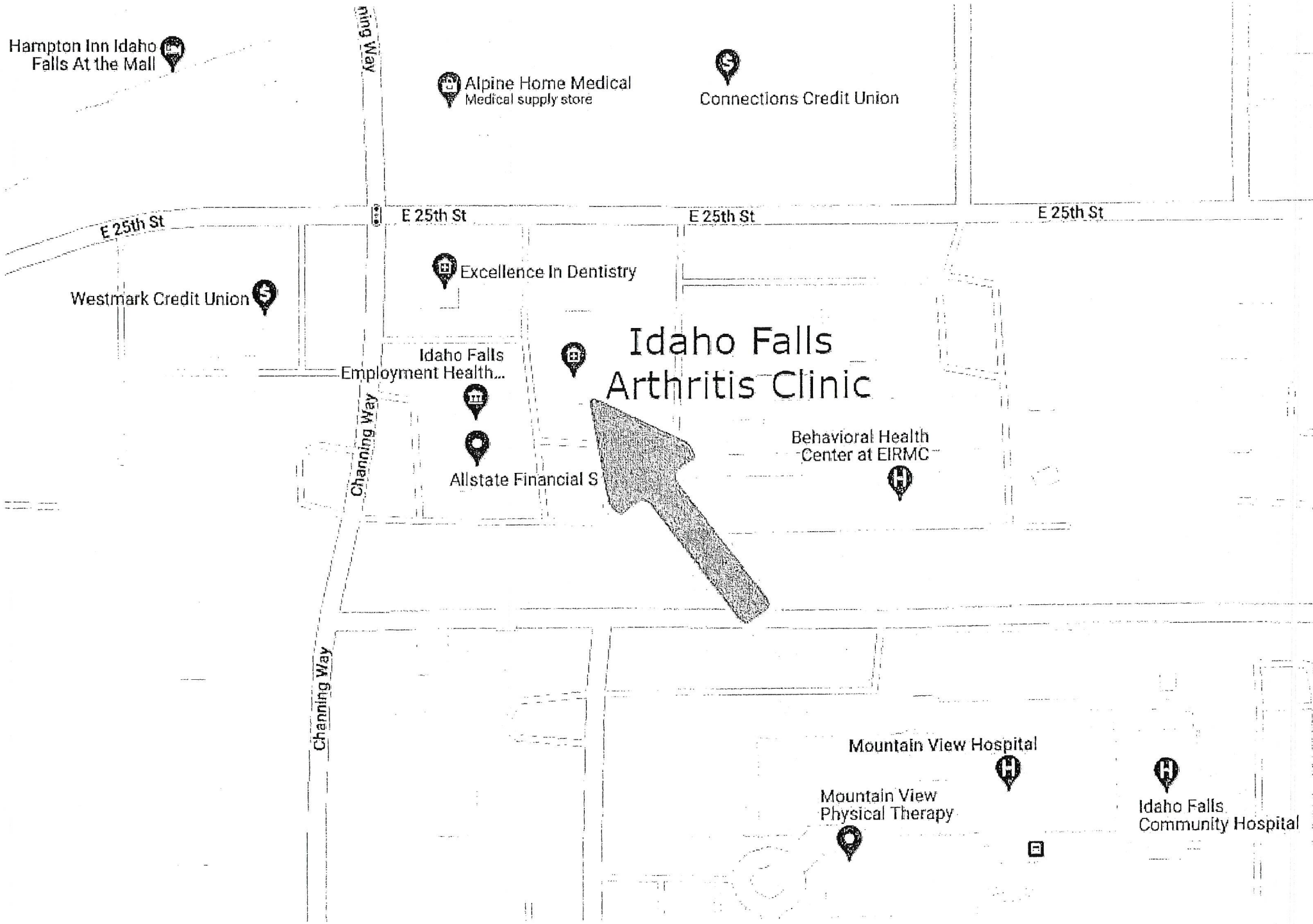
Disclosure may be made to: IDAHO FALLS ARTHRITIS CLINIC
2220 East 25th Street
Idaho Falls, ID 83404
Phone: (208) 542-9080
Fax: (208) 542-9081

I give Idaho Falls Arthritis Clinic authorization to disclose my personal appointment and medical information to the individuals list below (family members, spouse, etc.). I understand if their names are not listed here, no information will be shared without a signed consent from me.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____


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 Employment Health...
Idaho Falls Arthritis Clinic
Channing Way
Allstate Financial S
Behavioral Health Center at EIRMC
Channing Way
Mountain View Hospital
Mountain View Physical Therapy
Idaho Falls Community Hospital