PATIENT REGISTRATION FORM

Patient Name _____
Last **First** **Middle**

Birthdate _____/_____/_____ ☐**Male** ☐**Female** ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced**

Social Security _____-_____-_____ **Spouse Name:** _____

Street Address _____ (_____)_____
Home Phone

City, State, Zip_____ (_____)_____
Cell or Pager

Employer_____ (_____)_____
Work Phone

Insurance Information

**Is your insurance an affordable care plan? ☐Y ☐N If yes, you will immediately become cash pay.
*Did you sustain an injury at work? ☐**Y** ☐**N** Are you covered under an employer or union policy? ☐**Y** ☐**N**
We do not accept Workman's Compensation Insurance. If you answered Yes, STOP.

*Are your injuries accident related? ☐**Y** ☐**N** Is your spouse or other family member employed? ☐**Y** ☐**N**
*auto and personal injury claims are not filed by our office and the patient is responsible for payment
Are you currently employed? ☐**Y** ☐**N** Do you have a secondary insurance policy? ☐**Y** ☐**N**

Are you the primary policyholder/subscriber ☐Yes ☐No <u>If no, please fill out the following:</u>

Name of primary policyholder/subscriber_____

Policyholder/Subscriber's Birthdate _____/_____/_____ **Social Security**_____-_____-_____

Your relationship to policyholder ☐Spouse ☐Child ☐Stepchild ☐Other:_____

Nearest friend or relative that <u>does not</u> live with you:

_____(_____)_____ _____
Name **Phone** **Relationship**

How will you pay for visit? _____**Who referred you?**_____

Who is your primary care physician?_____

What is the reason for today's visit?_____

Have you seen another physician for this condition? ☐Yes ☐No If yes, who?_____

Have you ever had a <u>MEDICATION ALLERGY?</u> ☐Yes ☐No <u>If YES, list medications allergy:</u>

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures, and medical treatment by Ricardo Pocurull M.D., Rajpreet Singh D.O., Kati Langston PA-C, Laura Smith PA-C, his/her staff and designees, as may in his professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

_____ _____
Signature of Patient or Personal Representative Date

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review the Arthritis & Osteoporosis Clinic of Brazos Valley's Notice of Privacy Practices. This document explains how my medical information will be used and disclosed. I understand that diagnosis or treatment of me by my physician may be conditional upon my consent as evidenced by my signature on this document. I understand that I am entitled to receive a copy of this document. I am aware that copies are available in the lobby of the Arthritis and Osteoporosis Clinic of Brazos Valley and online at www.aocbv.com.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Patient or Personal Representative's Name Date

Do you feel comfortable with your ability to read and write? ☐ **Yes** ☐ **No**

Authorization to Release/Discuss Medical Information

I, _____, authorize Ricardo Pocurull M.D., Rajpreet
Print Patient Name
Singh D.O., Kati Langston, PA-C, Laura Smith, PA-C, or their designated representative to release or discuss information in my

health records to or with _____.
Print Name(s)

I realize that I have the right to rescind this designation at any time by writing the staff at Arthritis & Osteoporosis Clinic of Brazos Valley, PLLC.

_____ _____
Patient/Legal Representative Date

_____
Printed Name, if signed on behalf of the patient

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY
Financial Policy

We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. If you have any questions about the policy, please discuss them with the billing office at (979)696-8000 option 4. Please direct your questions about your financial responsibility *first* to your insurance company. However, do not hesitate to call us for questions about our statements to you.

Payment Options: For your convenience, we will accept cash, check, money order, VISA, MasterCard, Discover, and AMEX. A $25.00 service charge will be added to your account for all returned checks and must be paid before additional appointments will be scheduled. Restitution of the check must be made within 10 days or check will be given to the County Attorney for prosecution.

Appointments: Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. We reserve the right to charge for missed appointments. Currently, our no show fee is $50 and will increase at $10 increments for each missed appointment beyond 3. Excessive abuse of scheduled appointments may result in discharge from the practice. Reminders are a courtesy to you; you are responsible for your appointment even if you do not receive a reminder notice.

Insurance: You must provide proof of your currently effective insurance at each appointment. Unless you have health coverage, full payment is due at the time of service. We bill participating insurance companies as a courtesy to you. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your health care provider, our relationship is with you, our patient, not with your insurance company. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

HMO's: HMO's usually require authorization prior to all visits. It is the patient's responsibility to get that authorization from your primary care physician with the dates of service of your appointments. If we do not have a copy of this authorization at the time of service, we will reschedule your appointment until that authorization is available or you may pay for your entire visit prior to being seen by your provider. Amounts that your insurance pays will be refunded to you.

Medicaid: Medicaid requires all recipients to present their card when seeking medical attention, failure to do so may result in the rescheduling of your appointment.

Cash Pay: Payment is due at the time services are rendered. Patients are encouraged to ask for a quote from the billing department before services are received.

Services Rendered in the Hospital: We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Workmen's Compensation: We do not take Workmen's Compensation. We do not treat injuries incurred at work.

Minor Patients: For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

PRINT NAME:_____

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY
Financial Policy

Collection Agency: Any account that is given to our collection agency due to non-payment will have a 30% collection charge added to the account. Our collection agency will then collect the past due amount plus the 30% collection charge.

Disclosure of Financial Interest in AOCBV Laboratory and Intrafusion Infusion Suite

This disclosure is provided to you prior to any referral to the facility for laboratory services or the infusion suite in order for you to have an opportunity to select a different laboratory or infusion clinic to provide the services. You may choose not to utilize the AOCBV laboratory and/or Intrafusion infusion suite.

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to Ricardo Pocurull, MD, FACR, Kati Langston, PA-C, Rajpreet Singh, DO, FACR, Laura Smith, PA-C for professional services rendered. I authorize the release of any medical information needed to process claims. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

ARTHRITIS & OSTEOPOROSIS CLINIC OF BRAZOS VALLEY
1725 Birmingham RD, Ste. 200, College Station, TX 77845 · (979) 696-8000 · (979) 696-8100 fax
Board Certified in Rheumatology
Ricardo Pocurull, MD, FACR **Rajpreet Singh, DO, FACR**
Kati Langston, PA-C **Laura Smith, PA-C**

Joint Aspiration and Injection Acknowledgement Form

Patient: _____

1. Arthrocentesis or aspiration and injection of a joint are procedures commonly used by the AOCBV to improve joint function and provide pain relief as well as evaluation measures. This is an acknowledgement form for patient record identifying my acknowledgement of such procedures.
2. I understand that these are procedures performed by placing a needle into the joint or surrounding area. The goal is to withdraw fluid from the joint to provide pain relief, analyze the fluid under the microscope, and, possibly, inject medication into the joint to provide additional pain relief. I understand that the removal of fluid may be needed to find out why the fluid was present. I understand that fluid may re-accumulate after the removal. I understand that the medication that may be injected is a corticosteroid and may not provide long-lasting or permanent relief, and that no guarantee can be made about the outcome of my planned procedure.
3. Risks associated with joint aspiration and injection include the following:
    - Pain associated with the procedure if the needle touches joint surfaces
    - Increased bleeding, especially for those patients on blood thinning medications.
    - Damage to a nerve or joint surface from the needle or medication
    - Rare introduction of infection into the joint
    - Increased joint pain after injection of medication, or post-injection flare reaction
4. **I understand that I can refuse any procedure that is offered to me during my care at AOCBV.**

Initials: _____

Date: _____

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Controlled Substance Agreement For Narcotics Prescribed by AOCBV

I, _____, agree if AOCBV is prescribing a controlled substance that they will be the only physicians prescribing this medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a risk that I may become addicted to the controlled substances I am being prescribed. The risk is small where medication is taken as prescribed for pain.
- I understand that my physician may require that I have urine monitoring monthly for *Schedule II* medications, every 3 months for *Schedule III* medications. Should a concern about addiction arise during my treatment my physician may ask me to see a specialist in addiction medicine. I will comply with all requests for laboratory tests including random or scheduled urine monitoring for appropriate narcotic management as ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
- I consent to open communication between my doctor and any other health care professionals involved in my management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.

Refills Only:

- Please request refills through your preferred pharmacy. All controlled medications MUST be sent electronically to the pharmacy - we no longer have paper prescriptions for pick-up. Refills will not be filled on weekends, holidays, or sent out of state by the on-call provider, so please plan accordingly and all for in-office processing during our normal clinic hours.

_____ _____
Signature of Patient or Personal Representative Date

Appt Date:

Pocurull 1/9/2023

Patient Name:

Birth Date: **Sex:**

Rendering Provider: **MRN:**

Contact Information

Please review the information below and alert the front desk if this is incorrect or has changed

E-mail Address: Home Phone: Mobile

Address: Additional address info:

City: ST: Zip:

Emergency Contact

(Please fill out boxes below)

First name: Last name:

Day # Work # Cell #

Relationship: ☐ Spouse ☐ Daughter ☐ Son ☐ Mother ☐ Father ☐ Sister

☐ Other Please list here

Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life partner

Race: ☐ White ☐ African-American ☐ Asian ☐ Unknown

☐ American Indian/Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Refused/Declined

Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Occupation

What is your tobacco use history?

Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown

☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

	Current	Former	Never	Amount per day:	Number of Years:
Cigarettes	☐	☐	☐	Packs	
Cigar	☐	☐	☐	Cigars	
Pipe	☐	☐	☐	Pipes	

	Current	Former	Never	Amount per day:	Number of Years:
Chewing	☐	☐	☐	Ounces	
Snuff	☐	☐	☐	Ounces	
Smokeless (Electronic)	☐	☐	☐	Units	

Second-hand smoke exposure: ☐ Yes ☐ No

What is your alcohol use history?

Drinks alcohol: ☐ Yes ☐ No ☐ Formerly

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Number of drinks:

Drinks caffeine: ☐ Yes ☐ No

Review of Symptoms

Are you currently experiencing any of the following symptoms?

Constitutional Symptoms

- [ ] Chills
- [ ] Fatigue
- [ ] Fever
- [ ] Night Sweats
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Weakness

Eyes/ Ears/ Nose/ Throat

- [ ] Loss of Vision
- [ ] Blurry Vision
- [ ] Double Vision
- [ ] Dry Mouth
- [ ] Dry Eyes
- [ ] Pain in Eyes
- [ ] Loss of Hearing
- [ ] Hoarseness
- [ ] Jaw Pain
- [ ] Runny Nose
- [ ] Sores in Mouth
- [ ] Sore Throat
- [ ] Inflammation/Redness
- [ ] Tearing
- [ ] Bad Taste in Mouth
- [ ] Ear Ache
- [ ] Gritty Feeling in Eyes

Respiratory

- [ ] Cough
- [ ] Blood in Sputum (Hemoptysis)
- [ ] Shortness of Breath
- [ ] Wheezing

Cardiovascular

- [ ] Chest Pain
- [ ] Edema
- [ ] Palpitations
- [ ] Raynaud's Disease
- [ ] Murmur
- [ ] High Blood Pressure

Gastrointestinal

- [ ] Abdominal Pain
- [ ] Heartburn
- [ ] Loss of Appetite
- [ ] Nausea
- [ ] Vomiting
- [ ] Change in Bowel Habits
- [ ] Rectal Bleeding

Genitourinary

- [ ] Burning w/ Urination (Dysuria)
- [ ] Blood in Urine (Hematuria)

Endocrine

- [ ] Hair Loss
- [ ] Thirsty
- [ ] Gout
- [ ] Uncontrolled hunger
- [ ] Face Shape Change

Neurologic

- [ ] Dizziness
- [ ] Numbness
- [ ] Headache
- [ ] Memory Loss
- [ ] Tremors
- [ ] Burning in Extremities
- [ ] Loss of Balance

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Mood Changes
- [ ] Irritability
- [ ] Sleep Cycle Shift

Skin

- [ ] Hives
- [ ] Itching
- [ ] Nail Changes
- [ ] Sun Sensitivity
- [ ] Psoriasis
- [ ] Rashes
- [ ] Scalp Tenderness
- [ ] Dry Skin
- [ ] Skin Color Change
- [ ] Dandruff

Musculoskeletal

- [ ] Height Loss
- [ ] Joint Pain
- [ ] Joint Swelling/Stiffness
- [ ] Low Back Pain
- [ ] Morning Stiffness
- [ ] Muscle Cramps
- [ ] Muscle Weakness
- [ ] Neck Pain
- [ ] Loss of Motion
- [ ] Muscle Stiffness
- [ ] Fractures
- [ ] Pain When Walking Relieved by Rest
- [ ] Difficulty Doing Normal Activities of Daily Living

Hematologic/Lymph

- [ ] Abnormal Bleeding
- [ ] Easy Bruising
- [ ] Enlarged Lymph Gland
- [ ] Anemia
- [ ] Blood Clots

Past Fracture History

R	L	B	Please list location of fracture.	YEAR
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

Pocurull 1/9/2023

Past Medical History

Do you now or have you ever had: (check if "yes")

- ☐ Anemia
- ☐ Ankylosing Spodylitis
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer

Type:

- ☐ Cataracts
- ☐ Childhood Arthritis
- ☐ Colon Polyps
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gall Stones/ digestive disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High B/P
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Goiter/Thyroid disease
- ☐ Iritis/Scleritis
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Obesity
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Ulcerative Colitis
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Stomach Ulcer
- ☐ Seizure Disorder
- ☐ Shingles
- ☐ Stroke
- ☐ Tuberculosis

Other:

Past Surgical History

Have you ever had one of the following surgeries listed below (check & enter year)

- ☐ Angioplasty — Year
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Coronary Artery Bypass Surgery
- ☐ Cataracts
- ☐ Carpal Tunnel Release
- ☐ Cholecystectomy
- ☐ Weight Loss Surgery — Year
- ☐ Hernia Repair
- ☐ Hip Replacement
  Location: R ☐ L ☐ B ☐
- ☐ Knee Replacement
  Location: R ☐ L ☐ B ☐
- ☐ Liver Biopsy
- ☐ Pacemaker — Year
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Females Only

- ☐ Caesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Other:

How many miscarriages? ☐ How many pregnancies ?

Age at Menopause? ☐ How many births?

Past Treatment History

Have you ever had one of the following treatments listed below (check & enter year)

	Year		R	L	B	Year
☐ Physical Therapy	____	☐ Cortisone Joint Injection	☐	☐	☐	____
	____	☐ Hyalgan/Supartz/Euflexxa/ Synvisc Joint Injection	☐	☐	☐	____
	____	☐ PRP Joint Injection	☐	☐	☐	____

Family History

Do you know of any blood relative who has or had: (check if "yes")

	Mother	Father	Brother	Sister	Son	Daughter
☐ Alcoholism	☐	☐	☐	☐	☐	☐
☐ Ankylosing Spondylitis	☐	☐	☐	☐	☐	☐
☐ Antiphospholipid Syndrome	☐	☐	☐	☐	☐	☐
☐ Crohn's Disease	☐	☐	☐	☐	☐	☐
☐ Childhood Arthritis	☐	☐	☐	☐	☐	☐
☐ Dermatomyositis	☐	☐	☐	☐	☐	☐
☐ Illegal Drug Abuse	☐	☐	☐	☐	☐	☐
☐ Gout	☐	☐	☐	☐	☐	☐
☐ Osteoarthritis	☐	☐	☐	☐	☐	☐
☐ Osteoporosis	☐	☐	☐	☐	☐	☐
☐ Polymyositis	☐	☐	☐	☐	☐	☐
☐ Prescription Drug Abuse	☐	☐	☐	☐	☐	☐
☐ Psoriasis	☐	☐	☐	☐	☐	☐
☐ Psoriatic Arthritis	☐	☐	☐	☐	☐	☐
☐ Lower Back Pain	☐	☐	☐	☐	☐	☐
☐ Lupus	☐	☐	☐	☐	☐	☐
☐ Mixed Connective Tissue Disease	☐	☐	☐	☐	☐	☐
☐ Sarcoid	☐	☐	☐	☐	☐	☐
☐ Scleroderma	☐	☐	☐	☐	☐	☐
☐ Sjogrens	☐	☐	☐	☐	☐	☐
☐ Tuberculosis	☐	☐	☐	☐	☐	☐
☐ Ulcerative Colitis	☐	☐	☐	☐	☐	☐
☐ Vasculitis	☐	☐	☐	☐	☐	☐

Allergies

Are you allergic to any of the following: (check if "yes")

☐ Aspirin	☐ Codeine	☐ Latex	☐ Penicillin
☐ Cipro	☐ Eggs	☐ Levaquin	☐ Sulfa/Bactrim
☐ Lidocaine	☐ Ibuprofen	☐ No Known Allergies	☐ Other Allergies

Prior Testing

When was your last bone density scan?

M M – D D – Y Y Y Y ☐ Check here if date is approx.

Results:

☐ Normal

☐ Abnormal

What was the date of your last Tuberculosis skin test?

M M – D D – Y Y Y Y ☐ Check here if date is approx.

Results:

☐ Positive

☐ Negative

Appt Date: _____

Pocurull 1/9/2023

Patient Name:

Birth Date: **Sex:**

Rendering Provider: **MRN:**

This questionnaire includes information not available from blood test, x-ray, or any other source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can by yourself, if you need help, please ask. There are no right or wrong answers. Please answer exactly as you feel. Thank you.

1. Please place a (x) in the ONE best answer for your abilities at this time:

Over the last week, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** to do
a. Dress yourself, include tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
b. Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
c. Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
d. Walk outdoors on flat grass?	☐ 0	☐ 1	☐ 2	☐ 3
e. Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
f. Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
g. Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
h. Get in or out car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
i. Walk two miles or three kilometers if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
j. Participate in recreational activities and sports as you would like, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
k. Get a good nights sleep?	☐ 0	☐ 1	☐ 2	☐ 3
l. Deal with feeling of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
m. Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate how severe your pain has been:

No Pain ☐ 0 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 PAIN AS BAD AS IT COULD BE

Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing:

VERY WELL ☐ 0 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 2.5 ☐ 3 ☐ 3.5 ☐ 4 ☐ 4.5 ☐ 5 ☐ 5.5 ☐ 6 ☐ 6.5 ☐ 7 ☐ 7.5 ☐ 8 ☐ 8.5 ☐ 9 ☐ 9.5 ☐ 10 VERY POORLY

Have you have the COVID vaccine? NO YES Date Completed? _____

Have you had the booster? No Yes Date Completed? _____

Patient Name:

Appt Date:

Birth Date:

Sex:

Rendering Provider:

MRN:

Medications

Please list below all drugs and medications taken over the last week(including birth control pills, aspirin and any kind of drug or medication bought without a prescription.)

Name of Drug or Medicine	Dosage If Known	How Many Per Day	How Helpful is it (A lot)	(Some)	(None)	Any side Effects (Yes)	(No)	If Yes was it (GI)	(Skin)	(Other)
1			☐	☐	☐	☐	☐	☐	☐	☐
2			☐	☐	☐	☐	☐	☐	☐	☐
3			☐	☐	☐	☐	☐	☐	☐	☐
4			☐	☐	☐	☐	☐	☐	☐	☐
5			☐	☐	☐	☐	☐	☐	☐	☐
6			☐	☐	☐	☐	☐	☐	☐	☐
7			☐	☐	☐	☐	☐	☐	☐	☐
8			☐	☐	☐	☐	☐	☐	☐	☐
9			☐	☐	☐	☐	☐	☐	☐	☐
10			☐	☐	☐	☐	☐	☐	☐	☐
11			☐	☐	☐	☐	☐	☐	☐	☐
12			☐	☐	☐	☐	☐	☐	☐	☐
13			☐	☐	☐	☐	☐	☐	☐	☐
14			☐	☐	☐	☐	☐	☐	☐	☐
15			☐	☐	☐	☐	☐	☐	☐	☐
16			☐	☐	☐	☐	☐	☐	☐	☐
17			☐	☐	☐	☐	☐	☐	☐	☐

Preferred Pharmacy

Pharmacy Name:_____ Phone:_____Fax:_____

Address:_____ City:_____ ST:_____ ZIP:_____

Sign:_____ Date:_____