Mission Statement

To provide unsurpassed patient care and education and to conduct exceptional research.

By continuing to develop clinical and research expertise, maintaining local and national recognition for quality of care, and generating resources to ensure excellent service and foster growth.

Through a dedicated staff who care about our patients and each other and are committed to providing quality and uncompromising personal service.

Rheumatology Associates, S.C.

Rush-Presbyterian-St. Luke's Professional Building, Suite 365
1725 West Harrison Street, Chicago, Illinois 60612

Robert S. Katz, M.D.

Rheumatology — Internal Medicine

Telephone: 312–226–8228
Fax: 312–226–5572

Welcome to Rheumatology Associates, S.C.

Please fill out the enclosed forms and bring them with you to your appointment.

We look forward to seeing you.

Sincerely,

Robert S. Katz, M.D.

Robert S. Katz, M.D.

- Professor of Medicine, Rush Medical College
- Associate Professor of Medicine, Northwestern University School of Medicine
- Senior Attending Physician, Rush University Medical Center
- B.A., Columbia University
- M.D., University of Maryland
- Internal Medicine Internship and Residency, Washington University Medical Center, St. Louis
- Rheumatology Fellowship, Johns Hopkins Medical School, Baltimore
- Editorial Board, *Journal of Clinical Rheumatology*
- Chair, Abstract Selection Committee, American College of Rheumatology
- Editorial Review, *Arthritis & Rheumatism*, *Journal of Rheumatology*, *Journal of Clinical Rheumatology*
- Chair, Medical Advisory Board, Lupus Foundation of Illinois
- Board Member, Lupus Foundation of America
- Board Member, Lupus Research Institute
- Board Member, Arthritis Foundation
- Professional Achievement Awards, Lupus Foundation of Illinois
- Former Medical Editor, WBBM TV, WFLD TV; Reporter, CNBC TV
- Former Chair, *Chicago Sun-Times* Medical Advisory Board
- Former Chair, Medical & Scientific Committee, Arthritis Foundation
- Cited in *Castle Connolly Guide "America's Top Doctors,"* 1999–2008 (National and Chicago Editions)
- Cited in *Best Doctors in America* (Woodward and White, Publishers)
- Cited in "Chicago's Top Doctors," *Chicago Magazine*, all "best doctors" issues, including 2010
- *Guide to Top Doctors*, 1999–2007 editions
- Former President, Chicago Rheumatism Society
- R.S. Katz, M.D. and Rubschlager Chair for Arthritis Research, Rush Medical College
- Written more than 150 Original Academic Research Papers
- Conducted more than 95 Research Studies on new medications in Rheumatology
- Rheumatologist, Chicago White Sox

RHEUMATOLOGY ASSOCIATES, S.C.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Rheumatology Associates, S.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare organizations (TPO). Please refer to **Rheumatology Associates, S.C.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent.

Rheumatology Associates, S.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Carlen Katz, Privacy Officer, at 1725 West Harrison Street, Suite 1039, Chicago, Illinois 60612.

With my consent, **Rheumatology Associates, S.C.** may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, **Rheumatology Associates, S.C.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, **Rheumatology Associates, S.C.** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Rheumatology Associates, S.C.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the use and disclosure of my PHI by **Rheumatology Associates, S.C.** to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Rheumatology Associates, S.C.** may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

RHEUMATOLOGY ASSOCIATES S.C.

RUSH-PRESBYTERIAN-ST. LUKE'S PROFESSIONAL BUILDING, SUITE 365

1725 WEST HARRISON STREET, CHICAGO, ILLINOIS 60612

ROBERT S. KATZ, M.D.

RHEUMATOLOGY - INTERNAL MEDICINE

TELEPHONE: 312/226-8228

FAX: 312/226-5572

PATIENT INFORMATION

Name Last First M.I.

Maiden Name (if applicable) Sex ❑ Male ❑ Female

Address

City State Zip Code

Phone Home ( ) Work ( ) Cell Phone ( )

E-mail Address

Social Security Number Date of Birth Birthplace

REFERRAL INFORMATION

Primary Care Doctor Phone ( )

Address

Other Physicians (OBGYN, Ortho, other) Phone ( )

Address

Referring Doctor Phone ( )

Address

EMERGENCY INFORMATION (person to be contacted in case of emergency)

Name Last First M.I.

Relationship to Patient

Phone Home ( ) Work ( )

EMPLOYMENT INFORMATION

Occupation

Employer Name

Address

Phone ( )

HEALTH PLAN #1

Member Name Last First M.I.

Relationship to Patient Member SSN

Group Number Policy Number

Company Name

Address

Phone ( ) Effective Date

HEALTH PLAN #2

Member Name Last First M.I.

Relationship to Patient Member SSN

Group Number Policy Number

Company Name

Address

Phone ( ) Effective Date

BILLING INFORMATION

(Who is responsible for bills not covered by the health plan?)

Self ❑ Other ❑ (Please identify below)

Name Last First M.I.

Address

City State Zip Code

Phone Home ( ) Work ( )

Relationship to Patient

Have you applied, or are you planning to apply, for disability benefits?	❑ Yes	❑ No
Is this a workers' compensation case?	❑ Yes	❑ No
Is your problem related to an accident or injury?	❑ Yes	❑ No
If so, is litigation pending?	❑ Yes	❑ No

WE WOULD LIKE TO KNOW MORE ABOUT YOU.

How long have you been married?

What does your spouse/significant other do?

What do you and your spouse/significant other like to do together in your free time?

What are your hobbies, and how do you spend your leisure time?

AGREEMENT AND AUTHORIZATION

Financial Responsibility: I agree to pay to each of the applicable practices and/or services identified on the face page the established charges of all services, facilities, and supplies provided to me and/or dependents. I understand that payment may be required at the time of services. I agree to pay any balance not paid by my health plan, for whatever reason, subject to the applicable health plan contract. I understand that I will be billed for such services and I agree to make prompt payment regarding the same.

Release of Information: I understand that it is necessary that medical and financial information pertaining to me and my dependents be exchanged among and between the Medical Center, physicians providing services, and insurance companies and/or other paying agencies, and I consent to such exchange of information as may be necessary without further written authorization.

Assignment of Benefits: I hereby assign the Medical Center and physicians providing services to me and my dependents the medical and surgical benefits to which I and my dependents are entitled under my health insurance plan.

Patient Signature Date / /

Patient/Guardian Signature (required when patient is a minor) Date / /

Guarantor Signature (if applicable) Date / /

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birthdate: ____/____/____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT#) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____ Work (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age ____ ❑ Deceased/Age ____ Major Illnesses _____

EDUCATION (circle highest level attended):

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

Occupation _____ Number of hours worked/average per week _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____ **Example**

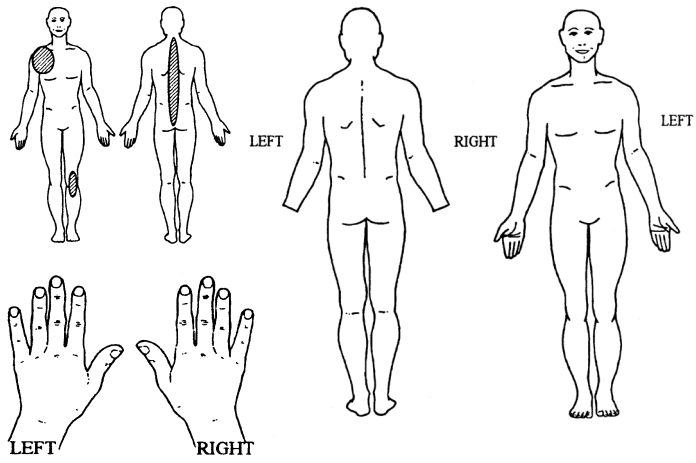
Diagnosis: _____

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:

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

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 (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Name _____ Date _____ Physician Initials _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last mammogram ____/____/____ Date of last eye exam ____/____/____ Date of last chest x–ray ____/____/____

Date of last Tuberculosis Test ____/____/____ Date of last bone densitometry ____/____/____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name _____ Date _____ Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No
If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now or have you ever 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	❑ HIV/AIDS	❑ High Blood Pressure
❑ Emphysema	❑ Glaucoma	❑ Tuberculosis

Other significant illness (please list) _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

Previous Operations

Type	***Year***	***Reason***
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____ List ages of each _____

Health of children: _____

_____

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

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever _____	❑ Tuberculosis _____
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy _____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism _____	❑ Psoriasis _____	

Patient's Name _____ Date _____ Physician Initials _____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS 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	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

Patient's Name _____ Date _____ Physician Initials _____

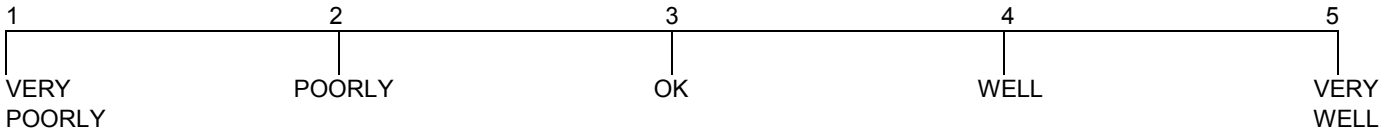
ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*



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

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 ❑

Patient's Name _____ Date _____ Physician Initials _____