



Suncoast Rheumatology

13425 S. BELCHER ROAD, LARGO, FL 33771
PHONE- (727)223-9610 FAX- (727)303-3193
suncoastrheumatology.com

Welcome to Suncoast Rheumatology

Our goal is to provide a good patient experience as well as delivering outstanding medical healthcare. The information on this cover sheet answers common questions our new patients have. We hope you will find this information helpful and reassuring. Should you have any further questions, please do not hesitate to call us. We look forward to seeing you in the office soon!

It is very important that you fill out the enclosed forms before your visit. Allow yourself 30 minutes to an hour to fill them out. Upon completion, you may either mail them to us prior to your appointment; or bring them with you when you come.

Plan to arrive 15 minutes before your appointment time. Doing so will allow the front office staff to process your information, and get you in to see the doctor on time.

Your first appointment will last for about 1-1/2 to 2 hours. Subsequent "follow-up" visits will usually last around 45 minutes to one hour. A recorded message will be sent confirming your follow-up visits 2 business days prior to your appointment.

Bring your insurance card(s) and driver's license with you for every visit. We will scan them before each appointment.

It is important to note that any co-pay amounts, or percentage totals that your insurance company requires, are processed when you check in. We accept cash, VISA, MasterCard, American Express and Discover.

Please bring all medications that you are currently taking. This includes vitamins and herbal supplements.

Should you need to cancel your appointment for any reason, we ask that you kindly give us 24 hours' notice of cancellation, so that the time set aside for you can be offered to someone else who needs to get in to see the doctor.

Thank you for your cooperation. We hope your visit is a pleasant one. And again, if you have any questions, feel free to contact our office at (727) 223-9610.

Sincerely,

All of us at Suncoast Rheumatology

Suncoast Rheumatology (SR)

Acknowledgment Form for Receipt of SR HIPAA* Notice of Privacy Practices

As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all that we can to secure and protect that privacy. We support your right to full access to your personal medical records.

*We have provided you with a detailed copy of our HIPAA Notice of Privacy Practices which comprises pages 3 – 7 of this patient packet. A copy of the SR HIPAA Notice of Privacy Practices is also available on our website:
www.suncoastrheumatology.com.*

We assure you that we strive to achieve the very highest standards of ethics and integrity in performing services for our patients. We have a HIPAA Compliance Program in place which provides guidelines, policies and procedures regarding appropriate use of our patients' PHI (Protected Health Information). All of our employees, managers, and providers continually undergo training in order to fully understand and comply with government rules and regulations regarding HIPAA with particular emphasis on the Privacy Rule.

If you have any concerns or objections, you may call our office at 727-223-9610; and ask to speak with our HIPAA Compliance Officer. There is also contact information for the Regional Offices of the Department of Health and Human Services and Department of Children and Families on the last page of our Notice of Privacy Practices (page 7 in your patient packet.)

Please sign & date this form to confirm that you have received your copy of our Notice of Privacy Practices. Thank you for being one of our highly valued patients.

I acknowledge that I have received a copy of the SR Notice of Privacy Practices.

Signature: _____ **Date:** ____/____/____

Print Name: _____

*HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by the United States Congress in 1996. The United States Government Department of Health and Human Services states that the HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.



Suncoast Rheumatology

13425 S. BELCHER ROAD • LARGO, FL 33771

PHONE- (727)223-9610 FAX- (727)303-3193

suncoastrheumatology.com

Susan L. Zito DO MPH FACR FACOI

Dual Board Certified - Rheumatology / Internal Medicine

NOTICE OF PRIVACY PRACTICES

Susan L. Zito DO, Suncoast Rheumatology

John Zito, Practice Administrator & Privacy Officer, (727)223-9610

Effective Date: June 7, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

- A. How This Medical Practice May Use or Disclose Your Health Information
- B. When This Medical Practice May Not Use or Disclose Your Health Information
- C. Your Health Information Rights

 - 1. Right to Request Special Privacy Protections
 - 2. Right to Request Confidential Communications
 - 3. Right to Inspect and Copy
 - 4. Right to Amend or Supplement
 - 5. Right to an Accounting of Disclosures
 - 6. Right to a Paper or Electronic Copy of this Notice

- D. Changes to this Notice of Privacy Practices
- E. Complaints

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer in the form of an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or

otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

23. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
24. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
25. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
26. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

27. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
28. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website: www.suncoastrheumatology.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you feel your privacy rights have been violated, or you disagree with a decision we made about your protected health information (PHI), you may file a complaint with the Secretary of the U. S. Department of Health and Human Services and/or the Department of Children and Families by contacting either agency at the addresses below:

- **The Department of Children and Families, Office of Civil Rights**

HIPAA Privacy Officer
1317 Winewood Blvd., Bldg. 1, Room 110
Tallahassee, FL 32399-0700
Phone: 850-487-1901
FAX: 850-921-8470

- **U. S. Department of Health and Human Services**

Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S. W.
Atlanta, GA 30303-8909
Voice Phone: 404-562-7453
FAX: 404-562-7881
TDD: 404-562-7884

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Date _____

Account: _____

Susan L. Zito DO

Board Certified Rheumatology
Board Certified Internal Medicine



13525 S. Belcher Road
Largo, FL 33771
Phone: (727) 223-9610
Fax: (727) 303-3193

Suncoast Rheumatology

PATIENT INFORMATION

Patient Name		Social Security	Age	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State	Zip Code	
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Spouse's Name	Phone	Cell Number	E-mail	
Please tell us who referred you to us:			Drug Allergies		

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses – If same as above check <input type="checkbox"/> Self	Name	Phone Number
Addressee	City	State Zip Code

I understand this clinic will not treat the aspects of my care that are part of a workers compensation claim. X

EMPLOYMENT INFORMATION

Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer (Father's if minor)
Address	City State Zip Code
Position	Business Phone Number
Spouse's Employer (or Mother's)	Address
Position	Business Phone Number

INSURANCE INFORMATION (Please list all)

Medicare Number	Medicaid No.	State
Insurance Co. Name & Address	Name of Policy Holder	DOB Social Security
Insurance Co. Name & Address	Name of Policy Holder	DOB Social Security

EMERGENCY INFORMATION

Person to contact in case of emergency other than person living in house with patient:				Relationship
Address	City	State	Phone Number	Cell Number

CONSENT FOR TREATMENT – RELEASE OF INFORMATION

I consent to treatment necessary for the care of the patient mentioned above. I hereby authorize the release of all medical records to referring physicians and to my insurance companies with the following exceptions.

X _____
Signature of patient or guardian

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED ATTACHED.

X _____
Signature

Thank You for taking time to complete this form. This information is necessary for the preparation of your clinic records. You are responsible for all charges as billed. Any service charges for past due or collection accounts will be the responsibility of the patient. As a courtesy, we will file your insurance or Medicare. However, your contract is with your insurance company. They are responsible to make payments directly to you. You are responsible for full payment as billed. If extended terms are desired on large balances, our credit office personnel will be happy to discuss a payment schedule most convenient for you.

Suncoast Rheumatology

13425 S. Belcher Road

Largo, FL 33771

Susan L. Zito, DO

Phone: (727) 223-9610 Fax: (727) 303-3193

MEDICAL INFORMATION

Name _____ Date _____ Medicare Number _____

OTHER INSURANCE:

Do you receive medical benefits from the Veteran's Administration?

NO YES Explain _____

Do you receive medical benefits from the Black Lung Program?

NO YES Explain _____

Do you receive medical benefits from a Medicare Program?

NO YES STATE _____ CARD NUMBER _____

Please show CURRENT card when returning this form.

Are you currently receiving medical benefits from a liability claim?

NO YES Explain _____

Are you currently receiving medical benefits from a workman's comp claim?

NO YES Explain _____

Are you employed? **NO YES WHERE _____**

If yes, do you have insurance with this company?

NO YES INSURANCE _____ NUMBER _____

Please show insurance card when returning this form.

Is your spouse employed? **NO YES WHERE _____**

Does your spouse have insurance coverage for you with this company?

NO YES INSURANCE _____ NUMBER _____

Please show insurance card when returning this form.

Do you have medical insurance other than Medicare and other than those listed above?

NO YES INSURANCE _____ NUMBER _____

Please show insurance card when returning this form.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Suncoast Rheumatology for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

SUNCOAST RHEUMATOLOGY

Health Questionnaire

Date of First Appointment _____ / _____ / _____ Birthplace: _____
Month Day Year

Name: _____ Birthdate: _____ / _____ / _____
Last First Middle Initial Maiden Month Day Year

Address: _____ Age: _____ Sex: F M
Street Apt. # Telephone: Home ()

City State Zip

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

Name of person making referral _____

The name of the physician providing your general medical care? _____

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

Describe briefly your present symptoms: _____

Date symptoms began (approximate) _____ Diagnoses given? (Please list) _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later) _____

Please list the names of other doctors you have seen for this problem: _____

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, toothbrushes, pencils, 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 other family members?	_____	_____	_____
In your sexual relationships?	_____	_____	_____
Engaging in leisure time activities?	_____	_____	_____
With morning stiffness?	_____	_____	_____
Do you use a cane, crutches, a walker, or a wheelchair? (circle item)	_____	_____	_____
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 ___	

Suncoast Rheumatology

MEDICATIONS:

List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium supplements, etc.

Name of Drug	Dose (Include Strength and Number of Pills per Day)	How long have you taken this medications?	Please Check: Helped?		
			A Lot	Some	Not At All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

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/Dosages	Length of Time	Results			Reactions
		A Lot	Some	Not at All	
1. Asprin/Zorprin					
2. Asprin—containing product					
3. Easprin containing Ascripten					
4. Disalcid/Salsalate/Trilisate					
5. Tylenol (plain) /with codeine					
6. Darvon/Darvocet					
7. Ansaïd					
8. Clinoril					
9. Daypro					
10. Feldene					
11. Indocin					
12. Lodine					
13. Meclomen					
14. Motrin/Rufen/Ibuprofen					
15. Nalfon					
16. Naprosyn					
17. Orudis/Orudis					
18. Relafen					
19. Tolectin					
20. Voltaren/Cataflam					
21. Cortisone/Prednisone/Medro					
22. Benemid/CoBenemid					
23. Colchicine					
24. Zyloprim/Lopurin/Allopurinol					
25. Gold (shots or pills)					
26. Plaquenil					
27. Penicillamine					
28. Methotrexate/Rheumatrex					
29. Imuran					
30. Cytoxan					
31. Azulifidine					

Reviewed by: _____ Date: _____

Suncoast Rheumatology

SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

GENERAL:

- Recent weight gain/Amount
- Recent loss of weight/Amount
- Fatigue/Tiredness
- Weakness
- Fever

NERVOUS SYSTEM:

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Numbness or tingling of hands and/or feet
- Memory loss

EAR:

- Ringing in ears
- Loss of hearing

EYES:

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

NOSE:

- Nosebleeds
- Loss of smell
- Sores in nose
- Dryness

MOUTH:

- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness

THROAT:

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

NECK:

- Swollen glands
- Tender Glands

HEART AND LUNGS:

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- High blood pressure
- Heart murmurs
- Cough
- Coughing blood
- Wheezing
- Night sweats

STOMACH AND INTESTINES:

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

KIDNEY/URINE/BLADDER:

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

BLOOD:

- Date of last eye examination _____
- Date of last chest X-Ray _____
- Date of last Tuberculosis Test _____
- Anemia
- Bleeding tendency

FOR WOMEN ONLY:

- Age when period began: _____ Periods regular: Yes No How many days apart: _____ Date of last period: _____
- Date of last Pap smear: _____ Date of last breast exam: _____ Date of last mammogram: _____
- Planning pregnancy? Yes No

SKIN:

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

MUSCLES/JOINTS/BONES:

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

SLEEP:

- How is your sleep? Good Fair Poor
- Do you get enough sleep? Yes No
- How many hours? _____
- Trouble getting to sleep? Yes No
- Do you awaken during the night? Yes No _____ # of Times
- Why? _____
- Do you awaken too early? Yes No
- Do you wake up feeling tired? Yes No

HABITS:

- Do you drink coffee? _____
 - Caf Decaf
- Cups per day? _____
- Do you smoke? Yes No Past
- Cigarettes per day? _____
- Do you drink alcohol? Yes No
- If so, how much per day or week? _____
- Do you use drugs for reasons that are not medical? If so, please list _____
- _____
- _____

Suncoast Rheumatology

DRUG ALLERGIES AND SIDE EFFECTS: YES NO

Name of Drug	Describe Reaction or Side Effect
1.	
2.	
3.	
4.	
5.	
6.	

SOCIAL HISTORY:

Never Married Married Divorced Separated Widowed
 Spouse: Alive/Age _____ Deceased/Age _____ Major Illnesses: _____

Number of people in household _____ (including you) Children _____ Age of youngest _____
 Occupation (yours): _____

EDUCATION: (*circle highest level attended*)

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

PAST PERSONAL HISTORY:

Do you or have you had: (check if 'yes')

Cancer _____ Heart Problems _____ Asthma _____ Inflammatory Bowel Disease _____
 Cataracts _____ Diabetes _____ Stomach ulcers _____ Nervous breakdown _____
 Anxiety/Nervousness _____ Rheumatic Fever _____ Bad Headaches _____ Irritable colon _____
 Kidney Disease _____ Pneumonia _____ Psoriasis _____ Anemia _____
 High Blood Pressure _____ Diverticulitis _____ Nervous stomach _____ Hayfever _____
 Other significant illness (please list): _____
 Pregnancies (how many) _____ Problems: _____

PREVIOUS OPERATIONS:

Including cataracts, plastic surgery, etc.

	Type	Year	Surgeon	City
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

Any previous fractures? No Yes Describe (location & year) _____
 Any other serious injuries? No Yes Describe (location & year) _____

Received By: _____
 Date: _____

Suncoast Rheumatology

FAMILY RHEUMATOLOGIC (ARTHRITIS) HISTORY:

At any time have you or a blood relative had any of the following? (Check if "yes")

blood relative who has the arthritic condition;
name/relationship

Arthritis (type unknown)	_____
Osteoarthritis	_____
Rheumatoid Arthritis	_____
Gout	_____
Lupus of "SLE"	_____
Ankylosing spondylitis	_____
Childhood arthritis	_____
Osteoporosis	_____
Psoriasis	_____
Ulcerative Colitis	_____
Crohns Disease	_____
Uveitis or Iritis	_____
Hemophilia or Blood Disorders	_____
Diabetes	_____

OTHER CONDITIONS: _____

NOTES: _____

Other Doctors you are currently seeing:

Would you like a copy of your evaluation sent to a physician? (check box to send copy)

Name: _____
Address: _____

Name: _____
Address: _____

Name: _____
Address: _____

Name: _____
Address: _____

Name: _____
Address: _____

Reviewed By: _____
Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. Circle the areas that swell. To complete the picture, please draw in your face.

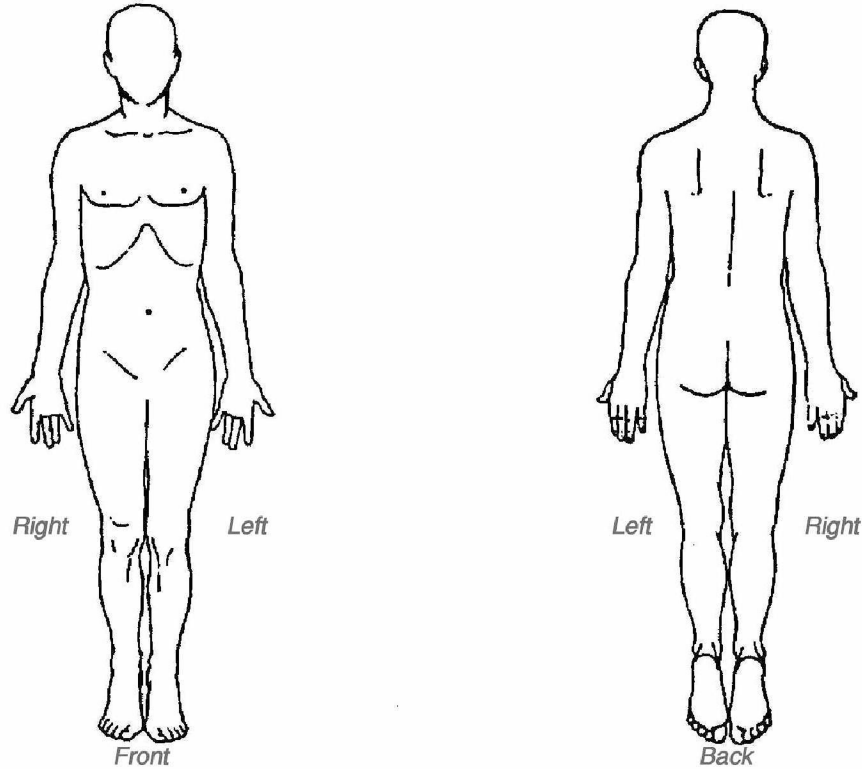
Aching
• • •

Numbness
= = =

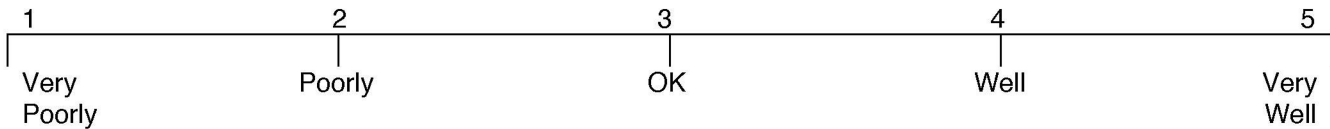
Pins and Needles

Burning
X X X

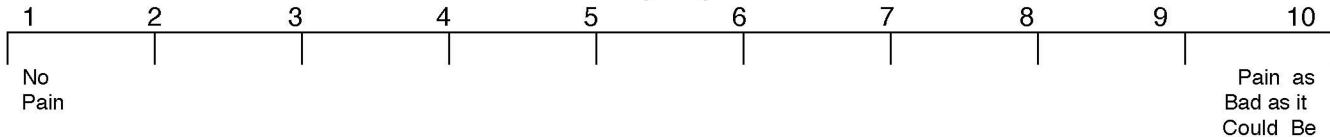
Stabbing
/ / /



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



On the scale below circle a number which describes your pain: Most of the time, I have



Suncoast Rheumatology
 13425 S. Belcher Road, Largo, FL 33771
 (727) 223-9610; Fax: (727) 303-3193
SUSAN L. ZITO, DO MPH FACR FACOI