RHEUMATOLOGY ASSOCIATES
Of Greater Houston, PLLC

Rheumatology Associates of Greater Houston, PLLC
Dr. Maryam Khawari, M.D.
777 S Fry Road, Ste 102.Katy, Tx 77450
Phone:(281)-652-5943. Fax:(281)-652-5944

PATIENT INFORMATION					
Name: Last	First	MI	Address:		
DOB:	Age:	Gender:	City:	State:	ZIP:
Home phone:			Cell phone:		
Social security No:			Email:		
Employer:			Work phone:		

EMERGENCY CONTACT		
Name:	Relationship with you:	Contact #
Name:	Relationship with you:	Contact #

CARE TEAM	
Name of Referring doctor:	Phone No:
Practice name/location:	
Name of Primary Care Physician:	Phone No:
Practice name/location:	

PHARMACY INFORMATION	
Preferred pharmacy:	Location:
Phone #	
Specialty pharmacy (if any):	Location:
Phone #	

INSURANCE INFORMATION			
Primary Insurance:		Name of policy holder:	
Relationship to patient: Self	Spouse	Child	Other
Group No:		Member ID:	
Secondary Insurance:			

HOW DID YOU HEAR ABOUT US		
Referral	Friend/Family	Insurance
Internet search	Newspaper	Other

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information for continuing patient care and treatment

From	To

Dr/Clinic/Hospital:	Dr.Maryam Khawari Rheumatology Associates of Greater Houston, PLLC
Address:	777 S Fry Road, Suite 102 Katy, TX 77450
Phone #:	281-652-5943
Fax #:	281-652-5944

Health information requested:

- Complete medical records
- Last consultation reports
- Discharge summaries
- Hospital records
- Immunization records
- Imaging reports
- Laboratory reports

Other (specify)_____

I understand that the specific information to be released may include but is not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease.

I understand this consent may be revoked at any time in writing, except to the extent that action has been reliance on it and that in any event this authorization shall expire 180 days from the date of my last signature unless specified in writing here.----------

Name in print _____ DOB_____

Signature _____ Date_____

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AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I understand that if the recipient authorized to receive the information is not a covered entity e.g. insurance company or non-health care provider, the released information may no longer be protected by Federal and State privacy regulations.

To the Party receiving this information:This information has been disclosed to you from records that confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

For Patient Records Applicable Under Federal Law 42 CRF PART 2:

Signature/Legal Authorized Representative:_____

Name (Last)_____ (First)_____ (Middle)_____

DOB_____ Date:_____

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CONSENT FOR EMAIL, TEXT MESSAGE AND AUTOMATIC VOICE REMINDERS AND NOTIFICATIONS

At Rheumatology Associates of Greater Houston PLLC, we believe in helping our patients with HIPPA compliant lines of healthcare communications. Patients in our practice may be contacted via email, text messaging or automatic voice messages to remind you of an appointment, to obtain feedback on your experience, to provide general health reminders and notifications, prescription refill messages, notifications for tests or other procedures.

We use **Spruce and Patient Fusion via Practice Fusion** for the health care communications, which are HIPPA compliant vendors. We respect your need for privacy; however, you are responsible for assuming the risks involved with activating any of the services. You understand that you are not required to provide consent to receive such information or advice from your healthcare.

By signing below, you are consenting to receive messages from our health care provider and medical staff, via text message, email, or automated voice message

Patient signature _____Print name _____Date_____

Terms and Conditions:

Your request to receive automated voice and text messages from your health care provider, constitutes your agreement to these terms and conditions. You agree that we may send you automated voice and text messages and emails through your wireless provider to the valid mobile or landline number and email address that you have provided to us. You agree to indemnify, defend, and hold us, our technology service vendors Spruce and Practice Fusion from any third-party claims, liability, damages, or costs arising from your request to receive automated voice or text messages with a phone number or email address that is not yours. You agree that we and our technology vendors will not be liable for failed, delayed, or misdirected delivery of any information sent to you or from you. This is a standard-rate messaging program where message and data rates may apply.

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PATIENT HISTORY FORM

Last name	First name	Middle name	DOB

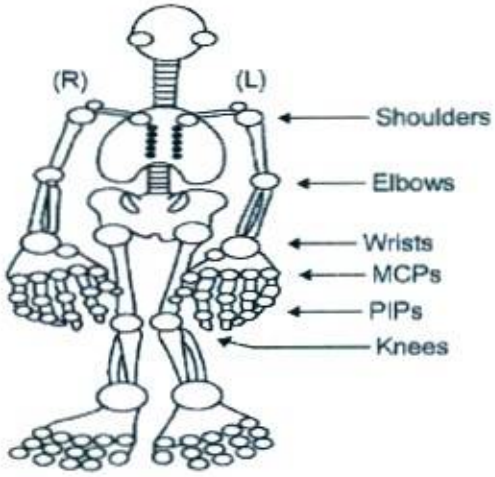
Briefly describe your present symptoms:
Approximate date symptoms began:

Rheumatological diagnosis and prior treatments for the rheumatological condition:

Prior rheumatologists/providers you have seen for this condition:

Tender Joints

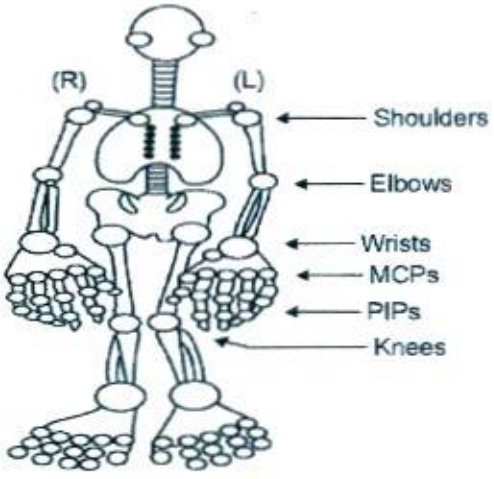
Patient: Using the diagram on the left, fill in the circles that represent the joints which are tender at the time of this visit.



Total Tender Joints _____
(No more than 28 total)

Swollen Joints

Physician: Using the diagram on the right, fill in the circles that represent the joints which are swollen at the time of this visit.



Total Tender Joints _____
(No more than 28 total)

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RHEUMATOLOGICAL DISEASES - Please check if you ever had or have any of the following:					
Disease	**Yourself**	**Relative**	**Disease**	**Yourself**	**Relative**
Gout	☐	☐	Osteoporosis	☐	☐
Osteoarthritis	☐	☐	Uveitis	☐	☐
Any bursitis/tendinitis	☐	☐	Childhood arthritis	☐	☐
Rheumatic fever	☐	☐	Ankylosing spondylitis	☐	☐
Lupus or SLE or skin Lupus	☐	☐	Psoriasis/Psoriatic arthritis	☐	☐
Rheumatoid Arthritis	☐	☐	OTHER:		

PAST MEDICAL HISTORY-Please check if you ever had or have any of the following:					
☐	High Blood Pressure	☐	Cancer	☐	HIV/AIDS
☐	Diabetes Mellitus	☐	Kidney disease	☐	Stomach ulcers/Reflux
☐	High Cholesterol	☐	Thyroid disease	☐	Colitis
☐	Heart problems	☐	Anemia	☐	Seizures
☐	Stroke	☐	Low platelet or white count	☐	Headaches/migraine
☐	Asthma	☐	Pneumonia	☐	Glaucoma
☐	COPD	☐	Tuberculosis	☐	Liver disease
☐	Jaundice	☐	Skin disease	OTHER:	
☐	Previous injuries	☐	Recurrent infections	OTHER:	

PAST SURGICAL HISTORY-Please list below		
Type	**Year**	**Reason**

FAMILY HISTORY-Please check and give relation		
Cancer	Heart disease	Hypertension
Diabetes	High Blood Pressure	Thyroid disease
Bleeding tendency	Blood clots	Stroke
Seizures	Alcoholism	Psych disease
Depression	Sickle cell	Genetic disease
Cystic Fibrosis	Colitis	OTHER

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Please list the approximate dates for the following:	
Last mammogram	Last chest X-Ray
Last eye examination	Last Tuberculosis test
Last Colonoscopy	Last Bone density test/DEXA

REVIEW OF SYSTEM

Constitutional	Respiratory	Genitourinary	Neurological
☐ Weight gain	☐ Shortness of breath	☐ Difficulty in urination	☐ Headache
☐ Weight loss	☐ Rest	☐ Pain/burning on urination	☐ Seizures
	☐ Walking		
☐ Fever	☐ Lying down	☐ Blood in urine	☐ Dizziness
☐ Night sweats		☐ Pus in urine	☐ Fainting
☐ Fatigue	☐ Chest pain	☐ Discharge from penis/vagina	☐ Loss of consciousness
	☐ Coughing blood	☐ Vaginal dryness	☐ Muscle spasm
Eyes	☐ Wheezing/Asthma	☐ Prostate disease	☐ Muscle weakness
☐ Dry eyes		☐ Decreased libido	☐ Memory loss
☐ Redness	**Cardiovascular**	☐ Other sexual difficulties	☐ Numbness/tingling
☐ Blurred vision	☐ Chest pain	☐ Frequent nighttime urination	
☐ Loss of vision	☐ Irregular heartbeat		**Psychiatric**
☐ Itchy eyes	☐ Murmurs	**Musculoskeletal**	☐ Excessive worrying
☐ Pain	☐ Leg swelling	☐ Morning stiffness	☐ Anxiety
	☐ Raynaud's	☐ Joint pain	☐ Easily losing temper
Ear/nose/mouth/throat		☐ Joint swelling	☐ Depression
☐ Nosebleed	**Gastrointestinal**	☐ Muscle weakness	☐ Agitation
☐ Nose ulcers	☐ Nausea	☐ Muscle pain	☐ Suicidal thoughts
☐ Mouth sores	☐ Vomiting		☐ Difficulty in falling asleep
☐ Dry mouth	☐ Stomach pain	**Integumentary**	☐ Difficulty in staying asleep
☐ Bleeding gums	☐ Diarrhea	☐ Easy bruising	
☐ Ringing in ears	☐ Constipation	☐ Rashes	**FOR WOMEN ONLY**
☐ Loss of hearing	☐ Heart burn	☐ Hives	☐ Age when periods began
☐ Loss of smell	☐ Blood in stools	☐ Sun sensitivity	☐ Are your periods regular?
☐ Loss of taste	☐ Black stools	☐ Nodules/bumps	☐ Date of last period
☐ Hoarseness	☐ Jaundice	☐ Hair loss	☐ Date of last pap
☐ Sore throat		☐ Skin tightening	☐ Bleeding after menopause
☐ Difficult swallowing	**Endocrine**		☐ Number of pregnancies
☐ Runny nose	☐ Cold intolerance	**Blood/Lymphatic**	☐ Number of miscarriages
☐ Frequent sneezing	☐ Excessive thirst	☐ Swollen glands	☐ Heavy periods
☐ Ear infections	☐ Excessive urination	☐ Anemia	
☐ Sinus infections		☐ Bleeding tendency	☐ Transfusion history
		☐ Blood clots	

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SOCIAL HISTORY		
Smoking-Current	Past/Quit date	Packs per day
Alcohol-Current	Past/Quit date	Quantity
Other recreational drugs		
Regular Exercise	Hour per week	Type
Sleep	Hours per night	Restful YES/NO

MEDICATION/FOOD/ENVIRONMENTAL ALLERGIES **If yes, please list and the reaction**	
Medication/food/Env	Reaction

CURRENT MEDICATIONS (List supplements, Herbal and over the counter medications as well)	
Name of drug	Dose (include strength and number of pills/day)

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Circle any of the following medication(s) you have taken in the past or currently

PAIN MEDICATIONS	PAST	CURRENT		PAST	CURRENT
Ibuprofen (Advil/Motrin)			Meloxicam (Mobic)		
Naproxen (Naprosyn/Aleve)			Aspirin (Full strength)		
Piroxicam (Feldene)			Hydrocodone (Lortab, Norco)		
Diclofenac (Voltaren/Arthrotec)			Tramadol (Ultram)		
Celecoxib (Celebrex)			Indomethacin (Indocin)		
Rofecoxib (Viox)			Codeine (Vicodin, Tylenol #3, or #4		
Acetaminophen (Tylenol)			Oxycodone (Oxycontin, Roxicodone)		
Sulindac (Clinoril)			Others:		

ORAL IMMUNOSUPPRESSANTS/PILLS	PAST	CURRENT		PAST	CURRENT
Gold pills or shots			Olumiant (Baricitinib)		
Methotrexate (Rheumatrex)			Sulfasalazine (Azulfidine)		
Azathioprine (Imuran)			Tofacitinib (Xeljanz)		
Apremilast (Otezla)			Cyclophosphamide (Cytoxan)		
Hydroxychloroquine (Plaquenil)			Mycophenolate mofetil (Cellcept)		
Steroids (prednisone, dexamethasone)			Others:		

INJECTABLE OR INFUSION IMMUNOSUPPRESSANTS	PAST	CURRENT		PAST	CURRENT
Cyclophosphamide (Cytoxan)			Rituximab (Rituxan)		
Adalimumab (Humira)			Infliximab (Remicade)		
Etanercept (Enbrel)			Golimumab (Simponi)		
Certolizumab (Cimzia)			Tocilizumab (Actemra)		
Abatacept (Orencia)			Kineret (Anakinra)		
Ustekinumab (Stelara)			Corticotropin (Acthar)		
Canakinumab (Ilaris)			Guselkumab (Tremfya)		
Belimumab (Benlysta)			Tofacitinib (Xeljanz)		
Baricitinib (Olumiant)			Upadacitinib (Rinvoq)		
Risankizumab (Skyrizi)			Sarilumab (Kevzara)		
Secukinumab (Cosentyx)			Ixekizumab (Taltz)		

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OSTEOPOROSIS	PAST	CURRENT	OSTEOPOROSIS	PAST	CURRENT
Alendronate (Fosamax)			Ibandronate (Boniva)		
Risedronate (Actonel)			Zolendronate (Reclast)		
Teriparatide (Forteo)			Denosumab (Prolia)		
Calcitonin (Calcimar, Miacalcin)			Abalopariride (Tymlos)		
Romosozumab (Evenity)					

GOUT MEDICATIONS	PAST	CURRENT		PAST	CURRENT
Colchicine (Colcrys)			Allopurinol (Zyloprim)		
Probenecid (Benemid)			Febuxostat (Uloric)		
Pegloticase (Krystexxa)			Rasburicase (Elitek)		

FIBROMYALGIA/CHRONIC PAIN MEDICATIONS	PAST	CURRENT		PAST	CURRENT
Amitriptyline (Elavil)			Gabapentin (Neurontin)		
Pregabalin (Lyrica)			Duloxetine (Cymbalta)		
Milnacipran (Savella)			Cyclobenzaprine (Flexeril)		
Carisoprodol (Soma)			Methocarbamol (Robaxin)		

Patient Signature _____

Date_____