Joo-Hyung Lee M.D

Joo-Hyung Lee, MD
Practice Limited to Rheumatology
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Dear New Patient______________________,

We would like to welcome you to our practice.

We apologize for the long wait for your initial appointment. If you feel that your problem requires more immediate attention, please ask to be placed on our cancellation list.

You must call and confirm your appointment TWO business days before your scheduled time. If we do not hear from you, we will assume that you do not intend to keep this appointment and another patient on our cancellation list will be given your time slot. If you show up without having confirmed your appointment, you may need to be rescheduled.

Your appointment has been scheduled on________________________, with Dr. Lee, at.______________AM/PM. Please take a few minutes to complete the attached forms before you come in for your scheduled appointment. Please do not mail the forms, but bring them with you to your appointment. Plan on being in our office for about one hour. It may take longer if lab and x-ray testing is needed.

Please bring the following items with you:

- **INSURANCE CARD**
- **AUTHORIZATION** - If your insurance requires an authorization for you to be seen in our office, please bring it with you to your visit. The Health Plans require that we have verified prior authorization in order to see you.
- **CO-PAYMENTS** are due at the time of your visit. Cash, Check, Visa, and Master Card are accepted.
- **X-RAYS** Please bring in any recent joint or bone x-rays related to your problem.
- **REPORTS** - This includes any recent lab and x-rays and relevant doctor's reports.
-

HMO, EPO, and **POS** insurance patients:
Make sure you have the proper authorization confirmed prior to your appointment.

If a patient does not have insurance, or if we can not verify eligibility, the patient is responsible for payment in full at the time of service.

Thank you for your courtesy and cooperation. We look forward to your visit.

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PATIENT INFORMATION

NAME	AGE	DOB
ADDRESS	PRIM. PHONE ( )	MOBILE? Y N
	SECOND PHONE ( )	
EMPLOYER	SSN#	
	DRIVER LIC #	
EMP. ADDRESS	OCCUPATION	
MARTIAL STATUS	EMERGENCY NAME	
(CIRCLE) M. W. D. S.	EMERGENCY # ( )	

GUARANTOR INFORMATION	
NAME	DOB
SOCIAL SECURITY	DIRVERS LIC #
EMPLOYER NAME	BUS. PHONE #
PERSON RESPONSIBLE FOR PAYMENT	
RELATIONSHIP	INSURANCE INFO (COMPANY NAME)
INSURANCE ADDRESS	
INSURANCE PHONE	
PATIENT REFERRED BY	
PATIENT'S PRIMARY CARE PHYSICIAN	
PATIENT'S PRIMARY PHONE NUMBER	
PATIENT PRIMARY ADDRESS	

We encourage you to discuss fee prior to your examination to avoid any misunderstandings. As a courtesy, your insurance will be billed- but it is not a guarantee of payment. Co-pays and deductibles are due at the time of service are rendered.

Consultation and treatment are provided solely for arthritis and related diseases. We therefore, require that all patients have a primary care physician (Internist, family or general practitioner) for their other medical problems and for emergencies. The undersigned understands the above and agrees to be legally responsible for any fees for professional services.

Patient Signature_________________________________ Date____________________

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Date of first appointment ____/____/_____ Time of Appointment ____________AM PM

Name (Last)________________(First)________________________(Middle Initial)______ (Maiden)_____________

Birth place________________________ DOB______/______/_______ Age_________ Sex (Circle). Female Male

Address____

Telephone Home______________________________ Work____

MARTIAL 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 Grad School __________________

Occupation_________________________________ Number of hours worked/average per week________________

Referred here by ____ Relationship_________________________

The name of the physician providing your primary medical care____

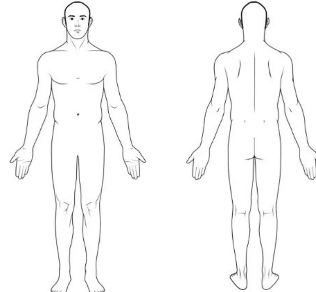
Do you have an orthopedic surgeon? YES NO If yes, name_______________________________________

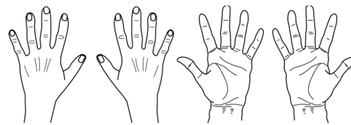
Describe briefly your present symptoms
____
____
____
____

Date symptoms began (approx.) ______________________
Diagnosis ____________________________________
Previous treatment for this problem (include physical therapy, surgery and injections; *medications to be listed*)
____
____
____

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.





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

Patient's Name____________________________________ Date________________Physician Initials__________

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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 wt gain amt________
- Recent wt loss amt________
- 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
- 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
- Persistant diarrhea
- Blood in stools
- Heartburn

GENITOURINARY
- Difficult urination
- Pain or burning or urniation
- Blood in urine
- Cloudy, “smoky” urine
- Puss 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 when__________
- Periods regular YES or NO
- How many days apart?___________
- Date of last period____/____/_____
- Bleeding after menopause? YES. or NO
- Number of pregnancies________
- Number of Miscarriages________

MUSCULOSKELETAL
- Morning Stiffness
  Lasting how long?
  _______Mins ________Hrs
- 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
- Hairloss
- Color changes of hands or feet in the cold

NEUROLOGICAL SYSTEM
- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hand 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
- Increase susceptibility to infection

Patient’s name_______________________________________Date____________________Physician’s Intitals_______

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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

- Cancer
- Goiter
- Cataracts
- Nervous breakdown
- Bad headaches
- Kidney disease
- Anemia
- Heart problems
- Leukemia
- Diabetes
- Stomach ulcers
- Jaundice
- Pneumonia
- HIV/AIDS
- Glaucoma
- Asthma
- Stroke
- Epilepsy
- Rheumatic fever
- Colitis
- Psoriasis
- High blood pressure
- Tuberculosis

Other significant illness(please list)
____
____

Natural or Alternative therapies (chiropractic, magnets, massages, over-the-counter- preparations, etc.)
____
____
____

Previous Operations		
Type	Year	Reason
1		
2		
3		
4		
5		
6		
7		

Any previous fractures? YES NO Describe____
Any other serious injuries? YES NO Describe____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF 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________________
- Leukemia______________
- Stroke________________
- Colitis________________
- Heart Disease_________________
- High blood pressure___________
- Bleeding tendency_____________
- Alcoholism___________________
- Rheumatic fever______________
- Epilepsy____________________
- Asthma_____________________
- Psoriasis____________________
- Tuberculosis________________
- Diabetes___________________
- Goiter_____________________

Patients name___________________________________Date ____________________ Physician Initials ________

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MEDICATIONS
Drug allergies NO YES To what?
____
____
Type of reaction____

PRESENT MEDICATONS
(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 a 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 MEDICATION 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 result 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(NSAID)							
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) Feldene (piroxicam) Indocin (Indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (Ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolecin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren(Diclofenac)							
Pain Relievers							
Acetaminophen (tylenol)							
Codeine (vicodin, Tylenol 3)							
Propoxyphene (Darvon/ Darvocet)							
Other:							

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Other:							
Disease Modifying Antirheumatic Drugs (DMARDS)							
Auranotin, gold pills (Ridaura)							
Gold Shots (Myochrysine or Solganol)							
Hydroxychloroquine (Plaquenil)							
Pennicillamine (Cuprimine or Depen)							
Methorexate (Rheumatrex)							
Azathioprine (Imoran)							
Sulfasalazine (Azulfidine)							
Quinacrine (atabrine)							
Cyclophosphamide (Cytoxan)							
Cyciosporine A (sandimmune or Neoral)							
Etanerecept (Enbrel)							
Infliximab (Remicade)							
Prosorba Column							
Other:							
Other:							
Osteoporosis Medications							
Estrogen (Premarin, Etc.)							
Alendronate (Fosamax)							
Etidronate (Didronel)							
Raloxifene							
Fluoride							
Calcitonin injection or nasal (miacalcin, calcimar)							
Risedronate (actonel)							
Other:							
Other:							
Gout Medications							
Probenecid (Benemid)							

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Colchicine							
Allopurinol (Zyloprim/ Lopurin)							
Other:							
Other:							
OTHERS							
Tamoxifen (nolvadex)							
Tiludronate (skald)							
Hyalgan/Synvisc Injection							
Herbal or Natural Suppl.							

Please list supplements
____
____
____
____

Have you participated in any clinical trials for new medications? YES NO
If yes, list
____
____
____
____
____
____

Patient Name ______________________________________Date______________________Physician Initials________