CABRILLO CENTER FOR RHEUMATIC DISEASE

Date: _____

Welcome New Patient _____

You have been referred by Dr/NP/PA: _____

for _____

Your rheumatology consultation visit with Dr/NP _____

has been scheduled on _____

Welcome to the Cabrillo Center for Rheumatic Disease specialty clinic. Please initial below that you have read and understand our check in policy. Thank you for your time and effort in your healthcare, as we cannot do our best without your help.

Check In Policy for New Patients

YOU MUST ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT WITH YOUR NEW PATIENT PACKET COMPLETED. YOU WILL BE RESCHEDULED IF YOU DO NOT ARRIVE 30 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT AND/OR YOUR NEW PATIENT PACKET IS NOT COMPLETED. _____ (INITIAL)

Check In Policy for Follow-up Appointments

ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED FOLLOW UP APPOINTMENT TO ALLOW TIME TO UPDATE YOUR INSURANCE AND ADDRESS, PAY YOUR COPAY, AND COMPLETE VITALS. YOU WILL BE RESCHEDULED IF YOU DO NOT CHECK IN 15 MINUTES PRIOR TO YOUR FOLLOW UP APPOINTMENT. _____ (INITIAL)

Please note the following:

- We refer patients who need pain medication to pain specialty clinics.
- We refer patients back to their primary care physician for non-rheumatic issues. If you do not have a primary care physician we will refer you to one.
- Please bring an interpreter if you are concerned that you will be unable to provide an accurate history in English. Please bring copies of results of abnormal labs or x-rays (images if possible) that caused you to be referred to us.

Phone: 760-309-1288 Fax: 760-970-4270
1420 Ocotillo Dr. Ste B El Centro, CA 92243

CABRILLO CENTER FOR RHEUMATIC DISEASE

Cost of Filling Out Forms and Generating Letters:

Cabrillo Center for Rheumatic Disease charges for forms to be filled out by our office that are not pertinent to direct daily patient care paperwork (i.e. lab orders, x-ray orders, prescriptions, and medical records) as these forms create extra work that is not covered by your insurance. These forms are not considered a standard part of patient medical care. Below is an updated list of various forms not covered by insurance and their costs:

$0	Excuse note for work, school, or jury duty (Completed on a prescription pad paper note- no letterhead)
$20	Form requiring Signature only
$25	Department of Motor Vehicle parking placard form, Family Medical Leave Act form
$30/page	Letters requiring letterhead that are not disability related
$50/page	Disability forms and disability letters (separate appt may need to be made)
$0.50/page	Chart copies (if more than just a single lab or x-ray report or office note), but we can fax copies to any doctor at no cost.

Policy Statement

Privacy Practices: I understand that this medical office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting it in writing (either by mail or at my next appointment) and a revised copy may be sent in the mail or will be provided to me at the time of my next appointment. _____(INITIAL)
Please indicate whether you should like a copy of the Notice of Privacy Practices. _____YES _____NO

Confidentiality: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to abuse of a minor, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities. _____(INITIAL)

Cancellation: Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment within at least 24 hours notice, I will be billed a $25 cancellation fee. I understand that this fee is the patient's responsibility, as missed appointments are not covered by insurance. _____(INITIAL)

No-Show Policy: Patients are subject to a $50 charge for missing their scheduled appointment. This fee is the patient's responsibility, as it is not covered by insurance. _____(INITIAL)
If you do not show for your appointment three(3) times you may be discharged from the clinic _____(INITIAL)

Late Fee Policy: Patients that arrive _____minutes after their scheduled appointment time are not guaranteed to be seen the same day. Patients may reschedule for another day. _____(INITIAL)

CABRILLO CENTER FOR RHEUMATIC DISEASE

Insurance: This office will submit your insurance claims to you carrier at no cost to you. However, we are not in a position to guarantee payment from your insurance company because the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand that it is my responsibility to know if this is true. _____(INITIAL)

Prior Authorization: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s). _____(INITIAL)

Medical Records: I understand that CCRD will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party. _____(INITIAL)

Medications: I understand that medical refills will be considered during office hours only. This is so the office can conform with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of CCRD, or obtaining medication illegally. I further understand that if I need to have a prescription refilled that I should contact my pharmacy 1-2 days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last 6 months. _____(INITIAL)

Agreements: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by myself. _____(INITIAL)

I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered. _____(INITIAL)

In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90 days from the date the claim was submitted, I agree that I will become responsible for the full amount for the balance on my account._____(INITIAL)

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs. _____(INITIAL)

Please sign below to indicate that you have read the Policy Statement and agree to the terms as stated

Signature:_____Date: _____

Coordination of Care:

Rheumatic diseases can affect many different body systems, which therefore can require communication between doctors of different specialties. In order to provide you with the most well-rounded care possible, your provider may request to see records/results of your visits with other providers. The following page is a form that will allow your other healthcare providers to share your health information with your provider at CCRD. This release is 100% voluntary, and can be revoked at any time.

CABRILLO CENTER FOR RHEUMATIC DISEASE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

Recipient: I authorize my health care information to be released to the following recipient(s):

Cabrillo Center for Rheumatic Disease
1420 Ocotillo Dr. Ste B El Centro, CA
92243 P: 760-309-1288 F: 760-970-4270

Purpose: I authorize the release of my health information for the following specific purpose:

Coordination of Care

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information:

_____

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the _____/_____/_____

☐ As long as I am under the care of Cabrillo Center for Rheumatic Disease

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Cabrillo Center of Rheumatic Disease. If I change my mind, I understand that I can revoke this authorization at any time by providing a written notice of revocation to Cabrillo Center for Rheumatic Disease. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

☐ I voluntary authorize the disclosure of my health information to the recipient named above:

Signature _____ Date: _____

☐ I do NOT authorize the disclosure of my health information to the recipient named above:

Signature_____Date: _____

CABRILLO CENTER FOR RHEUMATIC DISEASE

Responsible Party Information

(Only if Responsible Party is not the Patient)

FIRST NAME	MIDDLE NAME	LAST NAME
BILLING ADDRESS	CITY	STATE/ ZIP
HOME PHONE	WORK PHONE	CELL PHONE
RELATIONSHIP TO PATIENT	SOCIAL SECURITY #	DRIVERS LICENSE #

Insurance Information

PRIMARY INSURANCE:		EFFECTIVE DATE:
INSURANCE PHONE:	CLAIMS ADDRESS:	
CITY:	STATE :	ZIP:
SUBSCRIBER'S NAME:	SEX:	BIRTHDATE :
SUBSCRIBER'S ID#:	GROUP#:	
SUBSCRIBER'S EMPLOYER:	DEDUCTIBLE $:	COPAYMENT $:
RELATIONSHIP OF PATIENT TO SUBSCRIBER (circle one):	Self Spouse Child Other	IF TRICARE SPONSOR SSN# OR BENEFIT # :
SECONDARY INSURANCE:		EFFECTIVE DATE:
INSURANCE PHONE:	CLAIMS ADDRESS:	
CITY:	STATE:	ZIP:
SUBSCRIBER'S NAME:	SEX:	BIRTHDATE:
SUBSCRIBER'S ID#:	GROUP#:	
SUBSCRIBER'S EMPLOYER:	DEDUCTIBLE $:	COPAYMENT $:
RELATIONSHIP OF PATIENT TO SUBSCRIBER (circle one):	Self Spouse Child Other	IF TRICARE SPONSOR SSN# OR BENEFIT # :

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN		PHYSICIAN PHONE	
PRIMARY CARE PHYSICIAN ADDRESS (IF KNOWN)	CITY	STATE	ZIP

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE	WORK PHONE	CELL PHONE

AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

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 work: _____

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: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

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

_____

_____

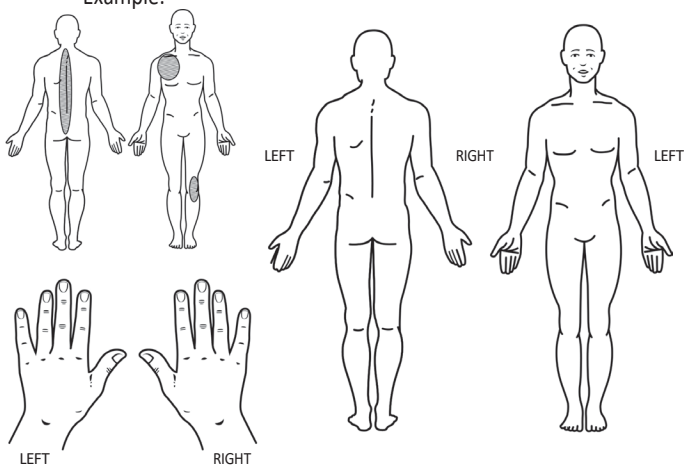
_____

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**.



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 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 swallowing

Cardiovascular

- ☐ Chest Pain
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure
- ☐ Heart murmurs

Respiratory

- ☐ Shortness of breath
- ☐ Difficulty 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 have 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 SURGERIES

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 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 If yes, please list:_____

_____

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/Dose	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		☐	☐	☐	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		☐	☐	☐	
Codeine		☐	☐	☐	
Propoxyphene		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Osteoporosis Medications					
Estrogen		☐	☐	☐	
Alendronate		☐	☐	☐	
Etidronate		☐	☐	☐	
Raloxifene		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal		☐	☐	☐	
Risedronate		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinol		☐	☐	☐	
Uloric		☐	☐	☐	
Krystexxa		☐	☐	☐	
Other:					

Patient's Name:_____ Date:_____ Physician Initials: _____

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Disease Modifying Antirheumatic Drugs (DMArDs)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloriquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Arava		❑	❑	❑	
Humira		❑	❑	❑	
Enbrel		❑	❑	❑	
Cymzia		❑	❑	❑	
Simponi		❑	❑	❑	
Orencia		❑	❑	❑	
Rituxan		❑	❑	❑	
Actemra		❑	❑	❑	
Kevzara		❑	❑	❑	
Xeljanz		❑	❑	❑	
Olumiant		❑	❑	❑	
Rinvoq		❑	❑	❑	
Stelara		❑	❑	❑	
Tremfya		❑	❑	❑	
Skyrizi		❑	❑	❑	
Cosentyx		❑	❑	❑	
Taltz		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
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...*

1	2	3	4	5
VERY POORLY	POORLY	OK	WELL	VERY WELL

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, walker or 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: _____

CABRILLO CENTER FOR
RHEUMATIC DISEASE

Are you interested in learning about our clinical trials?

☐ **Yes**, please contact me about ongoing studies

☐ **No**, I am NOT interested

Phone: 760-309-1288 Fax: 760-970-4270
1420 Ocotillo Dr. Ste B El Centro, CA 92243