Arthritis & Osteoporosis
CENTER OF SOUTHWEST OHIO
REMARKABLE RHEUMATOLOGY • REMARKABLE CARE

NEW PATIENT POLICIES

Welcome to the Arthritis & Osteoporosis Center of Southwest Ohio, a specialty Rheumatology practice. Our providers include Dr. Chacko Alappatt, Dr. Jessica Murphy, Maria Jones, Certified Nurse Practitioner (NP-C) and Mallory Michna, Certified Nurse Practitioner (NP-C). Our entire office strives to help you with your arthritis, autoimmune and bone health needs. For more information **www.ohioarthritis.com.**

To give the best care for our patients, we would appreciate your cooperation with the following policies:

- We have enclosed "new patient" paperwork. Please fill out the enclosed information forms and bring them with you to your appointment. **An even more efficient strategy is to send us your paperwork prior to your visit. We must have any pertinent medical records, lab results or x-rays forwarded to our office before your appointment. Without this information, your appointment may be delayed or rescheduled**

- AOC utilizes an automated appointment reminder system. The system will call, text or e-mail you two days prior to your appointment.
    - Please know that you must CONFIRM your appointment.
    - If you do not show for your new patient appointment and call back to reschedule you will **need to pay $100 deposit before rescheduling.**

- Please arrive 15 minutes early for your first appointment. If you are over 15 minutes late for your appointment you might be asked to reschedule as there will not be enough time to give you a complete arthritis evaluation.

- Please be sure to bring your insurance cards and be prepared to pay your co-pay at the time of service.

- Please make sure you have a referral from your primary care physician before your scheduled appointment (if your insurance requires one). Failure to have a referral on file in our office prior to your appointment may require payment in full at the time of service, or for the appointment to be rescheduled.

- Please bring any recent lab work with you.

- Please bring a list of your current medications (including doses) with you.

- Often, new patient consultations include having the doctor examine your knees, shoulders and feet. If you would feel more comfortable wearing shorts and a t-shirt instead of a gown, please bring those to change into.

- Please review Our Financial Policy that is included with this packet. We participate with many insurance plans and we will bill them as a courtesy to you. However, if we do not participate with yours, or you do not have insurance, you will be required to pay for the office visit portion when you check in. The cost of an initial Rheumatology evaluation without insurance is $250.00. An additional charge will be made for any imaging studies that may be needed. If laboratory studies are ordered you will get billed from the lab.

- We have one office location. **Miami Township Office** at 2960 Ferndown Drive, Miamisburg, Ohio 45432. The office is in the Exchange at Spring Valley retail and we are located behind the Roosters restaurant which is visible from State Route 741
  A detailed map is available at our website **www.ohioarthritis.com**

- Most of the conditions we treat are chronic conditions. If medication is prescribed to you AND this seems beneficial, you will require follow up visits. It is important to schedule these visits and it will be easiest to schedule those visits prior to leaving the office. At follow up visits you will receive enough medication refills to last until the next office visit. Asking a pharmacy to refill medications when you haven't been to our office for follow up in a reasonable time frame creates more work for our providers and may not be authorized. We will not be able to provide refills for your medications if you don't keep regular follow up visits. We understand that things come up and medication may need to be sent between visits; please allow 72 hours for this.
- Please realize that many of our patients have more than one pharmacy. Please try to keep up with what refills you will need and which pharmacy they go to prior to the office visit. Depending upon the medication, not all 90 day requests will be granted; if you need a 90 day refill, please voice this during your appointment
- If you are on a biologic or another relatively expensive medication, it is more than likely that your insurance will need a prior authorization and this may need to be done annually. It is important that you understand these rules and important dates and communicate these dates.
- Some medications require monitoring blood testing so please obtain lab work as instructed. Because we can assure quality of testing and timely receipt of results, we prefer that you do routine lab testing through our designated laboratory partner, LabCorp. We understand that a minority of patients may be out of network with LabCorp (mostly those who are employed/obtain insurance through Premier Health). If you choose to obtain labs through another lab, we cannot guarantee receipt of results and suggest you bring a copy of results to your next appointment.
- The field of Rheumatology is underserved in our area and to a large extent nationwide. Autoimmune and inflammatory disease are on the rise. Although our practice does better than most, we still struggle in getting new patients in for evaluation in a timely fashion. Referring physicians (like your own primary care physicians) expect our practice to evaluate their patients who are in need of our services. In general, our physician providers evaluate all new patients. For selected follow up appointments, you will be seen by one of our Nurse Practitioners. Our Nurse Practitioners have excellent experience, judgement and training. They work directly under and are supervised by our physician providers.
- Copays are set by your employer/ insurance and because we have contracts with these entities, we are required to collect copays. Copays are due prior to seeing our providers.
- We need to be notified with insurance changes (even if going on COBRA insurance).
- If you need certain employment paperwork completed (FMLA, Disability, etc) please allow adequate time for our providers to complete this paperwork. We ask that you allow up to 14 days and it is possible that you may need to meet with one of our providers with an office visit to detail what is required/requested. While each case will be dealt individually, due to practical constraints, we cannot guarantee that all paperwork will be completed. There will be a charge for paperwork left with our office between visits.
- Our office gets calls from hospitals, pharmacies, provider offices, labs, imaging centers, insurance companies, etc. Our staff and providers are focused on patients who are physically in our office. If you are having problems and think your medication regimen needs to be changed, please schedule an office visit. If you have questions which you feel do not require a visit, you can leave a message on the Medical Assistant voice line and we will get back with you. Please allow 72 hours for non-urgent questions. We do utilize an instant messaging system called Klara (www.klara.com) that can streamline communications. A link is available on our website.

☐ I have read and understand the AOC office policies and confirm by my signature below:

_____

Signature

Arthritis & Osteoporosis
CENTER OF SOUTHWEST OHIO
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NEW PATIENT INFORMATION

Please PRINT and COMPLETE ALL INFORMATION

Today's Date:_____

PATIENT INFORMATION

Is your visit related to a legal case? ◯Yes ◯No

Are you planning to apply for disability? ◯Yes ◯No

Patient Name:_____
Address:_____
City:_____State:_____Zip:_____
Home Ph#:_____Work Ph#:_____
Cell Ph#:_____
Employer Name:_____
Employer Address:_____
City:_____State:_____Zip:_____

How would you like to be addressed?_____
SS#_____ Marital Status:_____
Date of Birth:_____Sex: ◯M ◯F
Email:_____

Spouse's Name:_____
SS#:_____Date of Birth:_____

How did you hear about the AOCSO? ☐ Referring MD ☐ Family Member ☐ Friend ☐ Insurance Co. ☐ Website ☐ Employer ☐ NewspaperAd ☐ Internet Search ☐ Seminar ☐ Advertisement ☐ Hosp ER ☐ Other:

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL ☐ SELF

Insured (Responsible) Party Name:_____
Address:_____
City:_____State:_____Zip:_____
Home Ph#:_____Work Ph#:_____

Relationship to Patient: _____
Date of Birth:_____SS#:_____
Cell Ph#:_____

PHYSICIAN INFORMATION

Referring Provider:_____Phone#:_____Address:_____

Primary Care Provider: _____Phone_____Address_____

INSURANCE

Please have your insurance card(s) ready and available. We will be scanning this information into our system to bill your insurance for services.

Primary Insurance:
Policy Holder (if different than patient) ☐ SELF
Name:_____
Date of Birth:_____
Name of insurance_____

Secondary Insurance:
Policy Holder (if different than patient) ☐ SELF
Name:_____
Date of Birth:_____
Name of insurance_____

NOTIFY IN EMERGENCY: (PERSON NOT LIVING WITH YOU)

Name:_____
Address:_____

Home Ph#:_____Work Ph#:_____
Relationship:_____

☐ I authorize payment of medical benefits to physician or supplier for these services and all future claims.

_____
Signed (Insured or Authorized Representative)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Persons:	Dena Thompson, MHA / Practice Administrator
Telephone:	937-886-5510
Email:	d.thompson@aara.care
Address:	2960 Ferndown Dr; Miamisburg OH 45432

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to either the Contact Persons listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____(print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

HOME_____**WORK**_____**CELL**_____**OTHER**_____

Phone: for all the above numbers:

- ◯ leave messages on my answering machine.
- ◯ leave messages with any other person.

Mail: I want you to contact me at the following address_____

Email: I want you to contact me at the following email address _____

Fax: I want you to contact me by fax at _____

Other: Other requests for confidential communications (specify)_____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

◯Yes ◯No If Yes, person's Name:_____Relationship:_____

Phone: _____

I,_____(print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

You are entitled to a copy of this consent after you sign it. Include completed Consent in the patient's chart

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____(print name) have received a copy of this office's Notice of Privacy Practices.

Signature:_____Date:_____

OUR FINANCIAL POLICY

Welcome to the Arthritis & Osteoporosis Center of Southwest Ohio. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. The services you receive and the bill for those services is an agreement between you and the Arthritis & Osteoporosis Center of Southwest Ohio . **It is ultimately your responsibility to see that your bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Arthritis & Osteoporosis Center of Southwest Ohio within 8 weeks, it will be your responsibility to contact them. You will be notified of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. In the event a check is returned for any reason, a $35.00 charge will be made to your account.

Many insurance companies require a referral to a specialist prior to any appointment. **It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments.** To obtain a referral you will need to contact your physician and request one. Failure to have a referral on file in our office prior to your appointment will require payment in full at the time of service, or for the appointment to be rescheduled.

Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due prior to treatment. If you do not pay your co-pay at the time of service, a $5.00 re-bill charge will be added. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both The Arthritis & Osteoporosis Center of Southwest Ohio and you, please endorse the check and forward to us.
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the billing office. If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay charges. If you are unsure of self pay rates, it is your responsibility to ask. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service. We understand that temporary financial problems may affect timely payments on your account. If such problems arise, we encourage you to call us. We will be happy to work out a payment plan with you

If you do not have sufficient funds to cover a check or Debit card transaction, you will be charged $35 per item.

We have designated fees for forms that required the physician to fill out. The fees are due when we receive the forms. You may pay in cash, check or credit card. These fees vary based on the complexity of the forms. Forms may include: Disability, School and Work Physicals, Public Service Requests, FLMA and other miscellaneous forms.

NO SHOW & LATE CANCELLATION

If you are unable to make your appointment, **YOU MUST NOTIFY THE CLINIC AT LEAST 24 HOURS IN ADVANCE during regular business hours. Otherwise a $50 fee will be charged for a missed appointment.** You will be considered for termination from the practice if you have multiple no-show appointments.

☐ I have read the Financial Policy. I understand and agree to this Financial Policy.

Print Name:_____

Signed:_____ Dated:_____

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PATIENT HISTORY FORM

Name_____Date of Appointment_____

Date of Birth_____Age_____

Describe your Symptoms_____

_____

_____

_____

Date symptoms began_____Diagnosis_____

Previous treatment for this problem (include physical therapy, surgery, injections medications)

_____

_____

_____

_____

Please list the names of other practitioners you have seen for this problem

_____

_____

_____

_____

MEDICATIONS

Drug allergies ◯ Yes ◯ NO to what?_____

Type of reaction_____

Any other allergies ◯ Yes ◯ NO Explain_____

Name of Pharmacy_____Phone_____

Location:_____

PRESENT MEDICATIONS

NAME OF DRUG	DOSE	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.			☐	☐	☐
11.			☐	☐	☐

Patient initials_____
D.O.B _____

Referred by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Physician ☐ Other Health Professional

PAST MEDICAL HISTORY

Do you now or ever had: (check if "yes")

☐ Cancer type_____
☐ Fractures_____
☐ Asthma
☐ Bleeding Tendency
☐ Heart attack
☐ Diabetes
☐ Kidney Problems
☐ Childhood Arthritis
☐ Thyroid Problems
☐ Cholesterol
☐ Hepatitis
☐ Lupus or "SLE"
☐ Ulcerative Colitis or Crohn's
☐ Goiter
☐ High Blood Pressure
☐ Leukemia
☐ Alcoholism
☐ Angina
☐ Stomach Ulcers
☐ Osteoarthritis
☐ Psoriatic Arthritis
☐ Lung Problems _____type
☐ HIV/AIDS
☐ Ankylosing Spondylitis
☐ Rheumatoid Arthritis
☐ Psoriasis
☐ Depression/Anxiety
☐ Stroke
☐ Rheumatic Fever
☐ Epilepsy
☐ Heart Failure
☐ Liver Problems
☐ Gout
☐ Osteoporosis
☐ Anemia
☐ Glaucoma
☐ Scleroderma
☐ Arthritis (unknown type)
☐ Tuberculosis
☐ Other significant illnesses (please list) _____

SURGERIES:

☐ Total knee replacement (Right/Left/Both; date(s) _____)
☐ Arthroscopic Surgery (joint?_____; date(s)_____)
☐ Total hip replacement (Right/Left/Both date(s) _____)
☐ Back Surgery Lumbar/Thoracic/Cervical; date(s) _____)
☐ Carpal Tunnel Surgery (R/L)
☐ 'Trigger finger' surgery (Right/Left/Both; dates _____)
☐ Hysterectomy (date_____) (? Ovaries removed Y/N)
☐ Gall Bladder removal (date_____)
☐ Tonsils and Adenoid removal (date _____)
☐ Other

_____
_____
_____
_____

Patient initials_____
D.O.B _____

FAMILY HISTORY:

At any time has a blood relative had any of the following? (give relationship)

	Relative Relationship		Relative Relationship
Arthritis unknown type		Crohn's Disease	
Rheumatoid Arthritis		Ulcerative Colitis	
Psoriasis		Cancer	
Psoriatic Arthritis		Heart Disease	
Lupus		High Blood Pressure	
Gout/Gouty Arthritis		Bleeding Tendency	
Sjogren's Syndrome		Alcoholism	
Ankylosing Spondylitis		Asthma	
Osteoporosis		Hypothyroidism	
Childhood/Juvenile Arthritis		Diabetes	
Osteoarthritis		Stroke	
Other Arthritis Conditions			

SOCIAL HISTORY Primary language spoken: _____
Hand Dominance _____Right _____ Left
Education (circle highest level attended) ○ Grade School ○ High School ○ College
Occupation: _____
Number of hours worked/average per week _____
Employer: _____ Retired _____ Date _____
Military Service: _____yes _____No Current status: _____

MARITAL STATUS: ○ Never Married ○ Married ○ Divorced ○ Separated ○ Widowed
Spouse/Significant Other: ○ Alive/Age ____ ○ Deceased/Age ____
Do you smoke? ○ Yes ○ No ○ Past – How long ago? _____ Packs a day _____ Number of years _____
Do you drink alcohol? ○ Yes ○ No Number per week _____ Has anyone ever told you to cut down on your drinking? _____ Do you drink caffeinated beverages? ○ Yes ○ No Type of Beverage _____
Cups/-Glasses per day? _____ Do you use drugs for reasons that are not medical? ○ Yes ○ No If yes, please list:

_____

Activity Level: Sedentary _____ Moderate _____ Vigorous _____ Type of Exercise: Aerobic____
Golf_____ Jogging_____ Skiing_____ Swimming_____ Walking_____ Yoga____
Other _____ Exercise Frequency: _____ Times/week _____

Recent Travel: Out of State _____ International _____

_____

DIAGNOSTIC TESTS MRI Scan _____ CT Scan _____ Biopsy_____ Date of last eye exam _____ Date of last chest x-ray_____ Date of last Tuberculosis test _____
Date of last bone densitometry _____

Patient initials_____
D.O.B _____

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

CONSTITUTIONAL

☐ Fatigue ☐Fever ☐Malaise ☐Night sweats
☐ Recent weight gain (amount _____)
☐ Recent weight loss (amount _____)

HEENT ☐Eye dryness ☐Eye Pain ☐ Redness of eyes ☐ Visual Changes
☐ Loss of hearing ☐ Loss of smell ☐ Dry Mouth ☐Nose Bleeds ☐Sores in mouth ☐Difficulty swallowing ☐Hoarseness

RESPIRATORY ☐ Shortness of breath ☐ Cough ☐Coughing up blood ☐ Wheezing (asthma)

CARDIO VASCULAR ☐ Chest Pain ☐ Difficulty in breathing at night ☐ Swollen legs or feet
☐ Irregular heart beat

VASCULAR ☐ Cool extremity ☐Ulcer ☐ Raynaud's ☐ Thrombophlebitis

GASTROINTESTINAL ☐Abdominal pain ☐Jaundice ☐ Diarrhea ☐ Heartburn ☐ Vomiting
☐ Increasing constipation ☐ Nausea ☐Blood in stools ☐Changes in stools

GENITOURINARY ☐ Difficulty urinating ☐ Blood in urine ☐ Increased urinary frequency ☐ Urinary incontinence

REPRODUCTIVE ☐ Female Vaginal Discharge ☐ Breast Discharge ☐ Vaginal Dryness
☐ Sexual Dysfunctions ☐Irregular Menses ☐Penile Discharge ☐Sexual Dysfunctions

ENDOCRINE ☐Excessive thirst (Polydipsia) ☐ Abnormal sleep ☐Goiter ☐Tremors ☐Hair Changes

NEUROLOGICAL SYSTEM ☐ Gait disturbance ☐Headaches ☐Dizziness ☐Memory Loss
☐ Vertigo ☐Extremity Numbness ☐ Seizures

PSYCHIATRIC ☐ Depression ☐ Anxiety ☐ Insomnia

INTERGUMENTARY SKIN ☐ Sun sensitive (sun allergy) ☐Hair loss ☐ Rash ☐ Hives ☐ Skin Thickening

MUSCULOSKELETAL ☐Back pain ☐Joint pain ☐Morning stiffness (Lasting how long?_____) tenderness ☐Muscle Weakness ☐ Neck pain ☐Joint swelling ☐ Muscle pain

HEMATOLOGIC/LYMPHATIC ☐Eye bruising ☐Easy Bleeding ☐ Swollen Glands ☐ Anemia

ALLERGIC/IMMUNOLOGIC ☐ Asthma ☐ Seasonal Allergies ☐ Food allergies ☐ Environmental

PAST MEDICATIONS

Patient initials_____
D.O.B _____

NSAIDs

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Diclofenac (Voltaren)					
Etodolac (Lodine)					
Meloxicam (Mobic)					
Celecoxib (Celebrex)					
Ibuprofen (Motrin)					
Naproxen (Aleve)					
Nabumetone (Relafen)					
Rofecoxib (Vioxx)					
Indomethacin (Indocin)					
Piroxicam (Feldene)					
Sulindac (Clinoril)					
Ketorolac (Toradol)					
Other					

Disease Modifying Antirheumatic Drugs (DMARDS)

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Hydroxychloroquine (Plaquenil)					
Sulfasalazine					
Methotrexate (Trexal)					
Leflunomide (Arava)					
Azathioprine (Imuran)					
Minocycline					
Doxycycline					
Gold Salts					

Other oral medications for Rheumatoid/Psoriatic Arthritis

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Tofacitinib (Xeljanz)					
Apremilast (Otezla)					
Upadacitinib (Rinvoq)					
Baricitinib (Olumiant)					

PAST MEDICATIONS

Patient initials_____
D.O.B _____

Biologic Response Modifiers for Rheumatoid/Psoriatic Arthritis and Ankylosing Spondylitis

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Etanercept (Enbrel)					
Infliximab (Remicade)					
Adalimumab (Humira)					
Abatacept (Orencia)					
Tocilizumab (Actemra)					
Rituximab (Rituxan)					
Golimumab (Simponi)					
Certolizumab (Cimzia)					
Anakinra (Kineret)					
Sarilumab (Kevzara)					

Biologic Response modifiers for Psoriatic Arthritis

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Ustekinumab (Stelara)					
Secukinumab (Costentyx)					
Ixekizumab (Taltz)					

Osteoporosis Medications

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Estrogen					
Calcitonin					
Alendronate (Fosamax)					
Risedronate (Actonel)					
Ibandronate (Boniva)					
Zoledronic Acid (Reclast)					
Raloxifine (Evista)					
Teriparatide (Forteo)					
Denosumab (Prolia)					
Abaloparatide (Tymlos)					
Romosozumab (Evenity)					

PAST MEDICATIONS

Patient initials_____
D.O.B _____

Gout Medications

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Allopurinol (Zyloprim)					
Colchicine (Colcrys)					
Febuxostat (Uloric)					
Probenecid					
Pegloticase (Krystexxa)					

Non narcotic analgesics

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Duloxetine (Cymbalta)					
Milnacipran (Savella)					
Gabapentin (Neurontin)					
Pregalbin (Lyrica)					
Acetaminophen (Tylenol)					

Narcotic analgesics

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Tramadol					
Hydrocodone (Vicodin/Norco)					
Oxycodone (Percocet)					
Fentanyl (Duragesic)					
Tylenol w Codeine					
Tapentadol (Nucynta)					
Other					

PAST MEDICATIONS

Patient initials_____
D.O.B _____

Natural Supplements

	Length of time	Helped a lot	Helped some	Did not help	Medication reaction
Calcium					
Vitamin D					
Glucosamine/Chondroitin					
Curcumin/Turmeric					
Green Tea					
Fish Oil					
Other					

Have you participated in any clinical trials for new medications? ◯Yes ◯No If yes, list:_____

_____

_____

_____

_____

_____