EMORY CLINIC

Clifton Campus
1365 Clifton Road, NE
Building A, 3rd Floor
Atlanta, Georgia 30322
Ph: 404-778-4366

Midtown Campus
550 Peachtree Street, NE
Medical Office Tower, 15th Floor
Atlanta, Georgia 30308
Ph: 404-778-4366

Emory Rheumatology
at Decatur
2615 North Decatur,
Suite 110
Decatur, Georgia 30033
Ph: 404-251-1103

Division of Rheumatology

Dear Patient,

Welcome to the Emory Clinic Rheumatology practice. We look forward to partnering with you regarding your medical care. You have an appointment scheduled as a new patient in the Division of Rheumatology. **Please note: We have three locations. Please confirm your appointment location.** Please arrive 30 minutes prior to your appointment time to obtain parking and to begin your check-in process. We have provided the information below to make this initial visit as productive as possible. Your appointment time has been set aside especially for you, and we ask you allow plenty of time to arrive as traffic can be heavy and a delay can result in less time with the doctor.

What to Bring:

- The new patient questionnaire included in this packet, completed ahead of time to the best of your ability.
- All of your current medications including prescription and over the counter drugs as well as herbal supplements.
- Any records from your referring physician and any other Rheumatologist(s) you have seen, including lab tests and x-rays. (We prefer your records be mailed or faxed before your appointment. Please ensure they arrive **prior** to your appointment date.)
- A sweater or light jacket as the exam room can get chilly.
- Your current insurance card.

What to Expect:

- Please allow transit and parking time. It may take 30 minutes from the road and the parking deck to arrive at your doctor's office. It is helpful to arrive 15 minutes before your appointment time to check in.
- You may take all your medications the day of the visit and eat/drink as you normally would.
- You may be seen first by a resident or fellow who is working with your physician.
- Your medical history will be obtained and records reviewed.
- You may be asked to put on a gown for a physical examination.
- You may need further lab tests or studies such as xc rays. These can be performed at the Emory Clinic.
- At the end of your visit your diagnosis and treatment plan will be discussed with you and (if you wish) your family member.
- You will be notified by mail of the result of any tests or imaging studies done in conjunction with the visit within two (2) weeks of your visit.
- New Patient lab results may not be available for 10c 14 days after your visit.

Should you be unable to keep this appointment, or need to reschedule, please notify us as soon as possible by calling the number of your practice location listed at the top of this letter. Please notify us 24 hours prior to your visit, as this allows other patients waiting to get an appointment the opportunity to be seen. We look forward to your visit.

Sincerely,

The Division of Rheumatology

General Medication Refills

The Rheumatology Clinic at the Emory Clinic requires at least five business days notice for general medications to be refilled. Many of the medications given to you must be closely monitored for effectiveness and side effects. Depending on your condition, if you have not been seen by your doctor within a specified time period, medications may be declined, or only be prescribed for 30 days to allow you time to schedule an appointment with your doctor. Please try not to run out of medication prior to requesting a refill. Ensuring that your medication refills are up--to--date at every clinic visit is the safest, most efficient way to ensure you do not run out of essential medications.

Medication may not be refilled after office hours or on the weekends. Prescriptions for medications that we have not previously prescribed for you will not be filled.

Paperwork Request Policy

The Rheumatology Clinic at the Emory Clinic requires at least five business days notice for general medications to Please allow 7-10 business days for completion of any paperwork. In certain situations, an additional office visit may be required for certain types of paperwork to be completed.

Hospital Based Billing

Emory Healthcare is proud to have the privilege of providing your care. We want to ensure our patients know the Rheumatology clinic on the Clifton and Midtown campus is now a hospital outpatient department of Emory University Hospital Midtown (EUHM). In this structure, the hospital owns and operates an outpatient clinic and employs the support personnel involved in patient care.

This model will allow Rheumatology to expand access to care, support clinical pharmacists who can help manage medications, and increase healthcare initiatives within and outside our community.

How does this affect billing?

Under this structure, our patients may receive two charges on their billing statement as well as on their Explanation of Benefits
(EOB). One charge represents the facility fee charge and the second charge reflects the professional fee.

- The facility fee represents the costs of operating a building/facility for health care delivery and covers the cost of equipment, utilities, maintenance, supplies and medications administered during a clinic visit. The fee also pays for care by non-physician staff such as nurses, clinical pharmacists, and medical assistants.
- The professional fee represents charges for the professional services provided by the physicians in the clinic.

Depending on your insurance policy, you may see the facility fee charge applied to your hospital deductible and/or co-insurance. If you have an annual out-of-pocket maximum, these charges will apply only until you have met that amount.

Who to contact with questions

We recommend reviewing your insurance benefits or contacting your insurance provider to determine what your policy what your policy will pay what out-of-pocket expenses you may incur.

If you have further billing questions, please contact our financial counselor at 404-778-4650.

We value you as a patient and are honored to be your health care provider of choice.

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EMORY CLINIC

Narcotics Policy

Our doctors are committed to evaluating and treating pain at every visit. There are a multitude of options for treating pain including oral medications, physical therapy, exercise, relaxation techniques, use of heat and or cold, and acupuncture that we may prescribe or refer patients for. In most cases, treatment of the underlying medical condition will result in alleviation of pain. We offer conservative, narcotic-free treatment of chronic pain that is associated with rheumatologic conditions. Our clinic is not set up for the management of chronic pain with narcotics or opioids. In accordance with recommendations by the *Federation of State Medical Boards*, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

On some occasions, the use of narcotic medications may be an essential tool in the care of a patient. In accordance with the oversight of the *Georgia Medical Board* which governs safe and effective medical practices, our practice's policies are as follows:

1. On a first new patient visit, no narcotics or other controlled substances will be prescribed in the absence of a clear, acute injury.
2. In the interest of safety, patients requiring chronic pain medications must agree to obtain medications from only one physician and one pharmacy.
3. Prescriptions will not be filled outside of normal business hours, and will be subject to our customary medication refill policies.
4. New prescriptions will not be written for lost or stolen prescriptions.
5. If all of the prescribed medication is taken prior to the refill date, then the refill request will be denied.
6. Chronic pain or pain beyond that which is normally expected for a specific condition that continues to require narcotic medication will be referred to a pain management clinic.

EMORY HEALTHCARE | Epic

Work in Progress
On October 1, 2022, Emory Healthcare combined our multiple patient portals - Emory's Blue, Gold, Healthcare, Eye Center and Emory Decatur portals - into a single system. We can't wait to improve your experience as a patient.

Why are we making this change? Moving to Epic will:
- Allow you to access all of your Emory Healthcare medial records with a single sign-on
- Connect all of our hospitals and clinics to one software system
- Make it easier for you to manage your care online through the new MyChart patient portal

What do you need to do?
If you are currently signed up for any Emory Healthcare patient portal, you'll need to sign up for the new MyChart portal beginning **September 19, 2022.** MyChart will replace all current Emory patient portals.

MyChart is easy to use! beginning October 1, you'll be able to:
- View medications and request refills
- View test results
- Schedule certain appointments
- Check in for your appointments
- Send messages to your provider
- Join telehealth appointments
- View and pay co-pays, pre-payments and balances
- Obtain cost estimates

How do I sign up for MyChart? Sign up for the new MyChart patient portal at emoryhealthcare.org/epic.

There may be some slight delays, but safe and effective patient care is on top priority:
We know that during the first weeks of transition, there may be some slight delays. Your care team will need time to adjust to the new system. If there are any delays, your care team will communicate them to you as soon as possible.

During this transition, we will continue to deliver patient care with the same standards we do today. Patient safety and well-being remain our number one priority. Your care team will continue to have full access to your health information during this change.
Thank you for your patience and for entrusting us with your care!

Help Desk 404-727-8820

Visit emoryhealthcare.org/epic for everything you need to know about the switch to Epic and to learn how to sign up for MyChart.

AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

Patient History Form

Date of first appointment: ____/____/____ Time of 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 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 week _____

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: _____

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

Describe briefly your present symptoms: _____

_____

_____

_____

Date symptoms began (approximate): _____ **Example**

Diagnosis: _____

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

_____

_____

_____

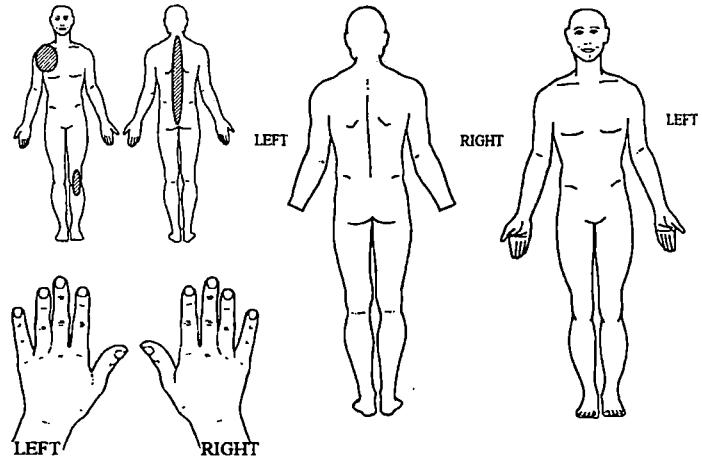
Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



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 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 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 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
- ❑ 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 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 Operations

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 of 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 To what? _____

_____

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/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
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) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	
Cyclosporine A (Sandimmune or Neoral)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Prosorba Column		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Patient's Name _____ Date _____ Physician Initials _____

PAST MEDICATIONS Continued

Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc injections		❑	❑	❑	
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 _____

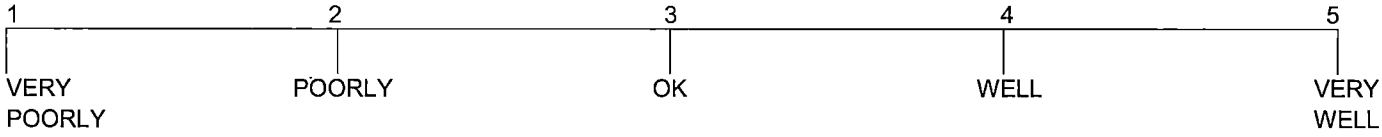
ACTIVITIES OF DAILY LIVING

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…*



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, as walker or a 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 _____