7300 Hanover Drive #201 9131 Piscataway Road #310

 Greenbelt, MD 20770 Clinton, MD 20735

7350 Van Dusen Road Suite 380

Laurel, MD. 20707

**Arthritis and Pain Associates of P.G. County**

Phone (301) 345-5600

Fax (301) 345-7715

Website - WWW.ARTHRITISPAINPG.COM

Dr. Jonathan Adelson - Dr. Donald Thomas - Dr. Yevgeniy Sheyn - Dr. Rukmini Konatalapalli - Dr. Maria Chou – dr. deborah kim

Dr. SAMYA MOHAMMAD - Maria Cuadra, PA-C - Chikako Riester, CRNP

**Welcome,**

 **\*\* Please arrive 45 mins - 1 hour early to allow our staff time to register you into our computer**

**So you are ready for your doctor on your appointment time. \*\*\***

Thank you for choosing our office to provide you with Rheumatological care. Our goal is to deliver Quality and Efficient care to you and your family members **Office and Telephone Hours**

Our office hours are Monday thru Friday 7:00 am – 3:00 pm. Phone calls are welcome. Our telephone hours are from 7:00 am – 3:30 pm. **Phones will be answered during our lunch hour 12:00 pm – 1:00 pm.** We have 3 Telephone Receptionists that will answer your call. If the lines are busy and you are directed to our voice mail, please: speak clearly and leave your name and number and reason for your call. One of our staff will get back to you by the end of the day or next business day.

**Insurance Requirements**

All HMOs require that you, as the patient, bring in a written referral to our office in order for us to see you. HMOs require referrals from your primary care physician for all visits & bone density x-ray testing. Cigna and Aetna may use electronic referrals. However, we still need to verify that you have a current referral on file. Problems with referrals occur daily: If you do not have a referral when you come in for your appointment, you have two choices:

1. Reschedule your appointment
2. Leave us a check-cash-Visa-MC-Discover Payment for the amount of the visit.

All co-pays are required at the time of your visit.

**List of insurances we accept***: HMO’S NEED REFERRALS*

AETNA US HEALTHCARE HMO & PPO, AMERIGROUP, MEDICARE PART B, BLUE SHIELD OF DC, MD, BLUE CHOICE (NEEDS REFERRAL), FEDERAL CAREFIRST, JOHNS HOPKINS EHP, MDIPA/OPTIMUM CHOICE (NEEDS REFERRAL), NCPPO ONE NET PPO, POS, GEHA (ONE NET PPO), TRICARE, CIGNA HMO & PPO, TRICARE PRIME(NEEDS REFERRAL) PRIVATE HEALTH CARE SYSTEMS (PHCS), UNITED HEALTHCARE PPO, USFHP (US FAMILY HEALTH PLAN (NEEDS REFERRAL).

**We do not accept:**

CIGNA HEALTH SPRING, CONVENTRY HEALTHCARE, EVERCARE, MEDSTAR HMO/PPO

GEORGE WASHINGTON UNIV HEALTH PLAN, KAISER, MEDICAID-MARYLAND MEDCIAL ASSISTANCE, PRIME HEALTH, PRIORITY PARTNERS, (UNITED HEALTHCARE STATE OF MARYLAND)

*If your insurance is not in any of the list above and you have a question whether our office accepts your insurance, please do not hesitate to call us.*

**\*\*\* Narcotic medication is not refilled unless you come in for an appointment. \*\*\* ATTENTION: Narcotic and Opioid Prescriptions WILL NOT be dispensed to any New patients on their first visit---If you currently take any of these medications please continue getting your refills from your current physician.  Thank you for making these arrangements before you arrive.**

|  |  |  |
| --- | --- | --- |
| 7300 Hanover Drive #201Greenbelt, Maryland 20770(301) 345-5600Fax: (301) 345-7715 | **Arthritis & Pain Associates of P.G. County**RHEUMATOLOGYLaurel Office7350 Van Dusen Road Suite 380Laurel, MD. 20707 | 9131 Piscataway Rd.Suite 310Clinton, Maryland 20735(301) 345-5600*TAX ID NO. 52-1939631* |
|  |  |  | DATE |
| PATIENT NAME | FIRST | MIDDLE |  |  | LAST | DATE OF BIRTH  |
| HOME ADDRESS APT. NO | CITY | STATE | ZIP CODE |
| OCCUPATION EMPLOYED [ ] FT. [ ] PT. RETIRED [ ] STUDENT [ ]  | SOCIAL SECURITY NUMBER | MARITAL STATUS[ ] S [ ] M [ ] D [ ]W | SEX | HOME PHONE |
| EMPLOYER (OR PREVIOUS EMPLOYER, IF RETIRED) | ADDRESS | WORK PHONE |
| E-MAIL ADDRESS | BEST NUMBER TO CONTACT YOU[ ] HOME [ ] CELL [ ] WORK | CELL PHONE |
| SPOUSE NAME | SPOUSE PHONE NUMBER [ ] HOME [ ] CELL [ ] WORK |
| EMERGENCY CONTACT | RELATIONSHIP | HOME/ CELL PHONE | WORK PHONE |
| ANY DRUG ALLERGIES/ IF SO, LIST |
| **WHO CAN WE THANK FOR REFERRING YOU :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****INSURANCE INFORMATION** |
| **PRIMARY INSURANCE COMPANY NAME** | ID OR POLICY NUMBER | GROUP/CODE |
| INSURANCE COMPANY ADDRESS | SUBSCRIBER’S SOCIAL SECURITY | DATE EFFECTIVE |
| SUBSCRIBER’S NAME | SEX | HOME PHONE | RELATIONSHIP TO PATIENT |
| SUBSCRIBER’S ADDRESSIS THIS THROUGH EMPLOYER [ ] | WORK PHONE | SUBSCRIBER’S DATE OF BIRTH |
| **SECONDARY INSURANCE COMPANY NAME**OR INDIVIDUAL [ ]  | ID OR POLICY NUMBER | GROUP/CODE |
| INSURANCE COMPANY ADDRESS | SUBSCRIBER’S SOCIAL SECURITY | DATE EFFECTIVE |
| SUBSCRIBER’S NAME | SEX | HOME PHONE | RELATIONSHIP TO PATIENT |
| SUBSCRIBER’S ADDRESS | WORK PHONE | SUBSCRIBER’S DATE OF BIRTH |
|  |

**PATIENT AUTHORIZATION**

I, hereby authorize Arthritis & Pain Associates of P.G. County to apply for benefits on my behalf for covered services rendered to me by Arthritis & Pain Associates of P.G. County I request payment from Medicare and/or my other health insurance be made directly to the above named Medical Practice or Physicians. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize copy of the authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature of Subscriber or Beneficiary

|  |  |
| --- | --- |
| Local Pharmacy: | ACCOUNT NUMBER |
| Mail Away Pharmacy: |
| Specialty Pharmacy: | RX Card and Bin Number: |

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**Family and Friends Contact Form**

Persons who are involved in you care (family, friends, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note in emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specially listed on this form).

**Please list those persons (including Family & Friends) with who we may share you information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such a message to include details (such as diagnosis, Lab results, Radiology results, medication information, appointment changes) at this number?**

Phone number you can leave a message on: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: Home Work Cell

Or (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle: Home Work Cell

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature or Patient or Legal Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name of Patient or Legal Representative Relationship to Patient**

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**Consent for Use and Disclosure of Protect Health Information**

We use information that you provide to us, including health information, to carry out treatment, payment and health care operations. Please refer to our “Notice of Privacy Practices” for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionists or by calling our office administrator at (301)-345-5600.

You have the right to request that we restrict the use of your health information to carry out treatment, payment or healthcare operations. We are not required to agree to the restriction. If we do agree to any restriction, the agreement is binding on use.

**I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operations purposes.**

Patient Name: (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient acknowledges receipts of Notice of Privacy Practices \_\_\_\_\_\_\_\_ (Initials & Date)

**HISTORY FORM**

*Information is important to your health; much is required for government and insurance. Answer every questions.*

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF APPOINMENT: \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **WHO REFERRED YOU?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **WHO IS YOUR PRIMARY CARE DOCTOR?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **WHO ARE YOUROTHER DOCTORS AND THEIR SPECIALITIES?** (use back if necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PAST MEDICAL HISTORY:** *(hepatitis, ulcers, psoriasis, high blood pressure, diabetes, heart disease, etc.)*

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**: DRUGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OTHER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MEDICAL HISTORY: *(What illness in family – arthritis, gout, lupus, thyroid, psoriasis, high blood pressure, colitis, inflammatory bowel disease fibromyalgia, ect,.)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL:**

**Exercise:** \_\_\_\_ Inactive \_\_\_\_ Light \_\_\_\_ Moderate \_\_\_\_ Heavy \_\_\_\_ Vigorous

**Nutrition:** \_\_\_\_ Well balanced diet \_\_\_\_ Poor balanced diet

**Sleep:** \_\_\_\_ daytime drowsiness \_\_\_\_ Difficult falling asleep \_\_\_\_ Difficult remaining asleep

 I get \_\_\_\_ hours of sleep/night on average.

**Alcohol Use:** \_\_\_\_ Nondrinker \_\_\_\_Drink> 4 drinks/day \_\_\_\_2-3 drinks/day \_\_\_\_<, drinks/day

 **Caffeine Use**: \_\_\_\_ Yes (type \_\_\_\_\_ servings a day \_\_\_\_) \_\_\_\_ No I don’t consume caffeine

**Recreational Drug Use:** \_\_\_\_In the past but quit (Types: \_\_\_\_\_\_\_\_) \_\_\_\_ Current User \_\_\_\_ Never Used

**Tobacco:** \_\_\_\_ Never smoked \_\_\_\_ Used to smoke (stopped \_\_\_\_ months/yrs. ago) \_\_\_Use Now Type? \_\_\_\_

**MEDICATIONS** (include vitamins and supplements):

|  |  |  |
| --- | --- | --- |
| **NAME** | **DOSE** | **FREQUENCY** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5 |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |
| 9 |  |  |
| 10. |  |  |

**PREGNANCY:** \_\_\_How many times? \_\_ How many live births? \_\_ How many miscarriages \_\_ How many abortions

**PREVIOUS SURGERIES:** *(tonsillectomy, hysterectomy, etc.)*

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH MAINTENANCE:** Have you had a Pneumovax (pneumonia vaccine)? \_\_\_ When? \_\_\_\_\_

Have you had the Flu Shot? \_\_\_\_ When? \_\_\_\_\_

Have you had a bone density x-ray (DXA scan)done? \_\_\_\_ When? \_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a TB skin test? \_\_\_\_ Result = \_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_

**HOSPITALIZATIONS**, *Medical: (pneumonia, infections, etc.)*

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What is you main reason for visit today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms:** If you joints are stiff in the morning, how long does it take to loosen up in average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Location on diagrams below:** Circle areas of recent pain on diagram if you have pain.



Pain Quality: Circle one (sharp, dull, aching, burning, stinging, throbbing)

Current Duration: How long has this episode been occurring? (\_\_\_ minutes, \_\_\_ hours, \_\_\_ days, \_\_\_ weeks)

Progression: Circle one: My conditions is (worsening, unchanged, improving)

**REVIEW OF SYMPTOMS**

(As you review the following list, please check any problems which have **SIGNIFICANTLY** affected you **RECENTLY)**

[ ] APPETITE LOSS [ ] ABDOMINAL MASS

[ ] EXCESSIVE CRYING [ ] ABDOMINAL PAIN

[ ] FEVER [ ] BLACK, TARRY STOOL

[ ] HAIR LOSS [ ] BACK PAIN

[ ] DRY SKIN [ ] JOINT REDNESS

[ ] RASH [ ] JOINT SWELLING

[ ] HEADACHE [ ] DECREASED MEMORY

[ ] DRY EYES [ ] FINGERS TURN COLOR WITH COLD

[ ] RED EYE (CONJUNCTIVITIS) [ ] NUMBNESS

[ ] NECK PAIN [ ] ANXIETY, EXCESSIVE WORRIES

[ ] NECK STIFFNESS [ ] DEPRESSION

[ ] SWOLLEN GLANDS [ ] DIFFICULTY SLEEPING

[ ] BLOODY SPUTUM [ ] APPETITE CHANGES

[ ] CHRONIC COUGH [ ] COLD INTOLERANCE

[ ] DIFFICULTY BREATHING [ ] HEAT INTOLERANCE

[ ] ABNORMAL BLOOD PRESSURE [ ] ABNORMAL BLEEDING

[ ] CLAUDICATION... walking calf cramps [ ] ANEMIA

[ ] EDEMA (Swollen Ankles) [ ] BLOOD CLOTS

**I attest that the above information is true and correct to the best of my belief.**

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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