Paula McMurtry, MD
Boone Health Rheumatology- Nifong
900 W Nifong Ste 101
Columbia, MO 65203
573-815-6633

Dear _______________

Welcome to Boone Health Rheumatology We look forward to seeing you for your scheduled appointment.

_________________________ at ___________

Please arrive 30 minutes early to your appointment You will need to arrive at ________.

1) Please complete the enclosed paperwork and bring it with you to your appointment Do not mail or e-mail it back to us You must arrive 30 minutes early to process your check-in as a first-time patient Failure to arrive early could result in the need to reschedule your appointment.

2) Bring your insurance card and photo ID and the enclosed paperwork completed

3) Any copay or coinsurance is due at the time of service We accept cash, check, Mastercard, Visa and Discover card.

4) If you do not plan to keep this appointment, please contact the office at 573-815-6633 to cancel or reschedule

We look forward to meeting you. Please call our office at 573-815-6633 with any questions or concerns

Sincerely,

Boone Health Rheumatology

Paula J McMurtry, MD

Adult Rheumatology

Patient History Form

Last Name ________________ First Name ______________ MI____ Maiden __________

Birthdate _____/_____/_____ Age_____ Birthplace ________________ ☐ Male ☐ Female
Month Day Year

Address ____
Street Apt # City State Zip Code

Home Phone ______________ Cell Phone ____________ Work Phone ____________

MARITAL STATUS ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse/SO ☐ 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 hrs worked/Average per week __________

Primary care physician ______________________ Diagnosis ____________________

Briefly describe your present symptoms ______________________________________

____________________________ Date symptoms began (approximate) ______________

Previous treatment for this problem

______________________________ ______________________________

____

____

Please list other practitioners you have seen for this problem

____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Condition	Yourself	Relative Relationship	Condition	Yourself	Relative Relationship
Arthritis (unknown type)			Lupus or SLE		
Osteoarthritis			Rheumatoid Arthritis		
Gout			Ankylosing Spondylitis		
Childhood Arthritis			Osteoporosis		

Other arthritis conditions ____

Patient Name ______________________ Date ____________ Physician Initials ________

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐ Yes ☐ No How many cups/glasses per day?_________

Do you smoke? ☐ Yes ☐ No ☐ In the past-How long ago? ___________

Do you drink alcohol? ☐ Yes ☐ No Number per week? _________

Have you ever been told to cut down on your drinking of alcohol? ☐ 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 of Exercise? ___________Amount per week _____

How many hours 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

Please list any other significant illness ____

Natural or Alternative Therapies (chiropractic, magnets, massage, over the counter preparations, ect)

____

____

Previous Operations

Type	Year	Reason

Any previous fractures? ☐Yes ☐No If yes, please describe______________________________

Any other serious injuries? ☐Yes ☐No If yes, please 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 children ______________

Health condition 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 ______________________ ☐Gout ______________ ☐Colitis ____________

☐Alcoholism ___________________ ☐Psoriasis __________________

MEDICATIONS

Drug Allergies ☐No ☐Yes If yes, please list drug and type of reaction______________________________

____

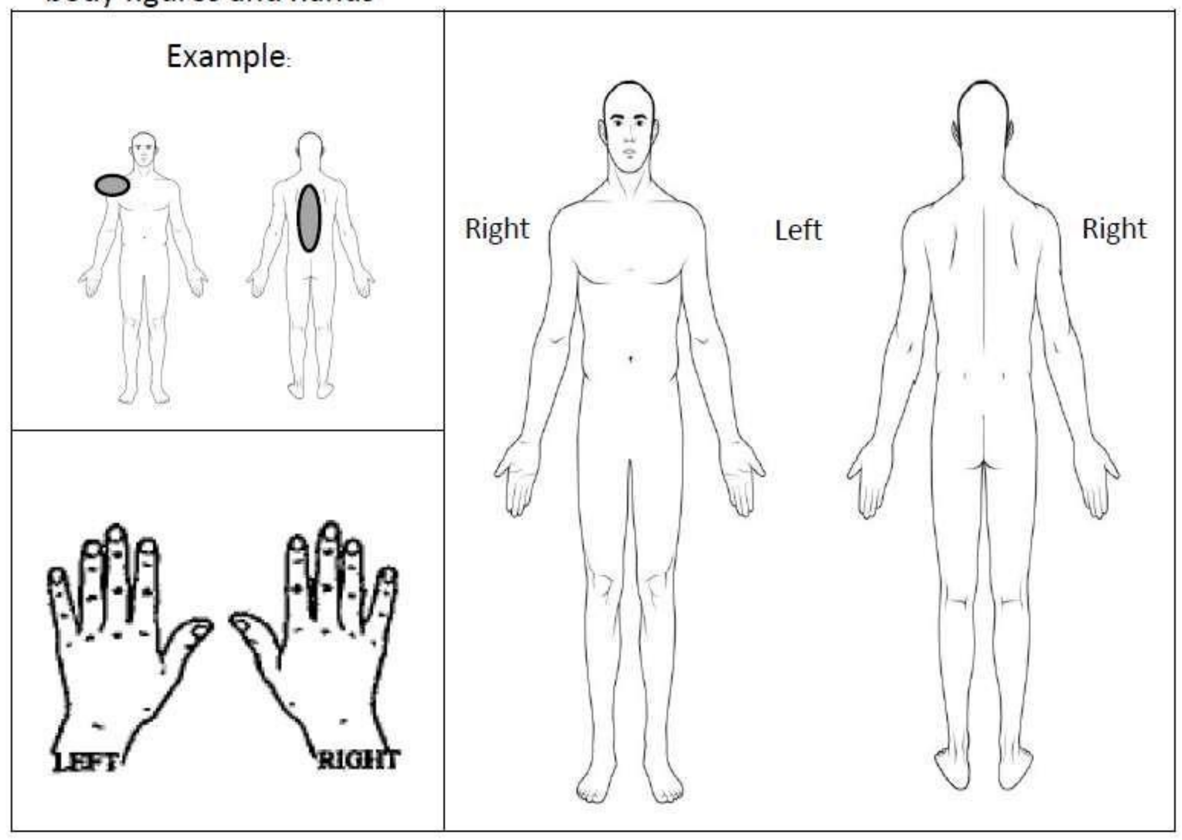
____

PRESENT MEDICATIONS (List all medications you take including vitamins supplements laxatives and prescriptions)

Name of Drug	Dose {strength (mgs) and number of pills per day}	How long have you taken this medication	Does it help? Please check		
			A lot	Some	None
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Additional Rheumatology Information

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



PAST MEDICATIONS

Please review this list of “arthritis” medications. As accurately as possible, try to remember which medication 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?			Reactions
		A Lot	Some	Not At All	
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 (salsafate)	Doloboid (diflunisal)
Feldene (piroxicam)	Indocin (indomethacin)	Lodine (etodolac)	Meclomen (meclofenamate)
Motrin/Rufen (ibuprofen)	Nalfon (fenoprofen)	Naprosyn (naproxen)	Oruvail (ketoprofen)
Tolectin (tofmetin)	Trilisate (choline magnesium trisalicylate)	Vioxx (rofecoxib)	Voltaren (diclofenac)

Drug names/Dosage	Length of time	Please check: Helped? A lot	Some	Not At All	Reactions
Codeine (Vicodin, Tylenol 3)		☐	☐	☐	
Propoxyphene (Darvon/Darvocat)		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Antirheumatic Drugs					
Auranofin, gold pills (Ridaura)		☐	☐	☐	
Gold shots (Myochrysine or Solganol)		☐	☐	☐	
Hydroxycholoroquine (Plaquenil)		☐	☐	☐	
Peniciliamine (Cuuprimine or Depen)		☐	☐	☐	
Methotrexate (Rheumatrex)		☐	☐	☐	
Azathioprine (Imuran)		☐	☐	☐	
Sulfasalazine (Azulfidine)		☐	☐	☐	
Quinacrine (Atabrine)		☐	☐	☐	
Cyclophosphamide (Cytoxan)		☐	☐	☐	
Cyclosporine A (Sandimmune or Neoral)		☐	☐	☐	
Elanercept (Enbrel)		☐	☐	☐	
Infliximab (Remicade)		☐	☐	☐	
Other:		☐	☐	☐	
Osteoporosis Medications					
Estrogen (Premarin, etc)		☐	☐	☐	
Alendronate (Fosamax)		☐	☐	☐	
Etidronate (Didronell)		☐	☐	☐	
Raloxifene (Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin Injection or Nasal (Miacalcin, Calcimar)		☐	☐	☐	
Risedronate (Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications					
Probenecid (Benemid)					
Colchicine					
Allopurinol (Zyloprim/Lopurin)					
Febuxostat (Uloric)					
Others					
Cortisone/Prednisone					
Hyalgan/Synvisc Injections					
Herbal or Nutritional Supplements					
Please list supplements:					

ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? __________
How many people in your household? __________ Relationship and age of each? ______________________
Who does most of the housework? ________________ Who does most of the shopping? ________________
Who does most of the yardwork? _____________

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

Please check the appropriate response for each question

Because of health problems do you have difficulty	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil)			
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, a walker or a wheelchair? Circle any you use
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 medical related lawsuit pending? ☐ Yes ☐ No

Patient Name
Med Rec Number: Acct Number:
Age: Gender: DOB Svc Date:

Health Insurance Portability and Accountability Act (HIPAA) - Release of Information

Patient's Name ______________________ Date of Birth ______________________

I authorize my providers at BooneHealth to share information regarding my medical condition and care coordination with the following members of my support system

Name ______________________ Relationship ______________________
Phone Number(s) ______________________ ______________________

Name ______________________ Relationship ______________________
Phone Number(s) ______________________ ______________________

Name ______________________ Relationship ______________________
Phone Number(s) ______________________ ______________________

Name ______________________ Relationship ______________________
Phone Number(s) ______________________ ______________________

Name ______________________ Relationship ______________________
Phone Number(s) ______________________ ______________________

______________________ ______________________
Patient Signature ***Staff Signature***

Patient Name
Med Rec Number: Acct Number:
Age: Gender: DOB Svc Date:

Consent to Treatment, Authorization of Benefits and Financial Responsibility

Consent to Treatment.

I know that I have the right to make decisions about my/my child s medical treatment. I consent to have the physicians and other health care workers at CH Allied Services Inc dba Boone Hospital Center Boone Hospital Center's Visiting Nurses Inc dba Boone Home Care and Hospice Boone Physician Services LLC dba Boone Medical Group and CHAS Physician Services LLC (collectively referred to herein as Boone') provide medical treatment to me/my child I understand the medical treatment is provided by physicians and health care workers who may be employees of Boone and other individuals allowed to provide care at Boone.

I consent to having photographs videos and other electronic images of me/my child taken and stored for treatment and education purposes I understand that reasonable efforts will be made to protect the identity of me/ my child

Assignment of Benefits and Financial Responsibility

I agree that the information I gave to apply for payment is correct for any third-party payers including Medicare or Medicaid I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my/my child's record to find out about payment or charges I may owe if Medicare or Medicaid will not cover my charges

If I receive Medicare Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions I also understand I am responsible for any deductibles co-insurance, and any non-covered charges I know that I may receive separate bills for services provided by healthcare workers who are not employed by Boone who are authorized to provide care at Boone

I authorize direct payment to Boone of all insurance benefits I understand that I am responsible, subject to Boone's Financial Assistance Policy to pay for portions of my/my child's bill not covered by insurance

I also agree that I have received or have access to signs and/or brochures which contain information about:

- Advance Directives What are they? Where can I get one? Do we need one?
- Privacy of my health care information and who may have access to my information
- How the hospital handles personal property (Hospital patients)
- I have been given the information regarding my right of choice in obtaining home care services (Home Care patients)
- Visiting/Office hours Visitor/Office Policies and Behavior Rules
- The rights and responsibilities I/we have as a patient or family member and who to contact if I have questions

I have read this whole form or had it read and explained to me and I had the opportunity to ask questions

____________________________ ____________________________

Signature of Person Consenting to Treatment **Relationship to Patient**

____

Signature of Guarantor if different than above

 This is a permanent part of the medical record

FORM ID

Patient Name:
Med Rec Number Acct Number
Age Gender DOB Svc Date

Acknowledgement to Share Information with a Health Information Exchange

CH Allied Services, Inc dba Boone Hospital Center, Boone Hospital Center's Visiting Nurses, Inc. dba Boone Home Care and Hospice, Boone Physician Services, LLC dba Boone Medical Group and CHAS Physician Services, LLC (collectively referred to herein as "Boone") participates in Midwest Health Connection (MHC) MHC is a nonprofit, community health information exchange (HIE) that facilitates electronic exchange of patient health information with physicians, hospitals, labs, pharmacies and other providers MHC will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through MHC helps Boone save patients' time and make better treatment decisions with a more complete record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications and other important data. See MHC's brochure for more information about how MHC helps us promote patient health and protects patient information Patients can also read more about MHC at https://www mhc-hie.org/

By initialing below, I understand that my participation in the HIE is voluntary and subject to my right to opt-out and I have been offered a copy of MHC's Brochure. MHC makes every effort to ensure that sensitive patient information, such as HIV/AIDS, mental health, and substance abuse treatment related information (sensitive) information, is blocked from viewing However, due to system limitations, Boone and MHC are limited in blocking sensitive information at this time

Init
____
Patient Initial

Acknowledgement to Opt-out of Sharing Information with a Health Information Exchange

I understand that I have the right to Opt-Out of having my patient information shared though MHC by signing an opt out form I may request an **Opt-Out Form** from Boone staff and they will help me complete it. Unless I opt-out, any authorized provider, health plan or other entity that participates in the MHC HIE, or is a member of a health information exchange that is connected to the MHC HIE, can electronically access and share my health information through the MHC HIE

Boone will not discriminate against you if you choose to sign an Opt-Out Form and Boone does not require you to share information through MHC in order to receive medical treatment.

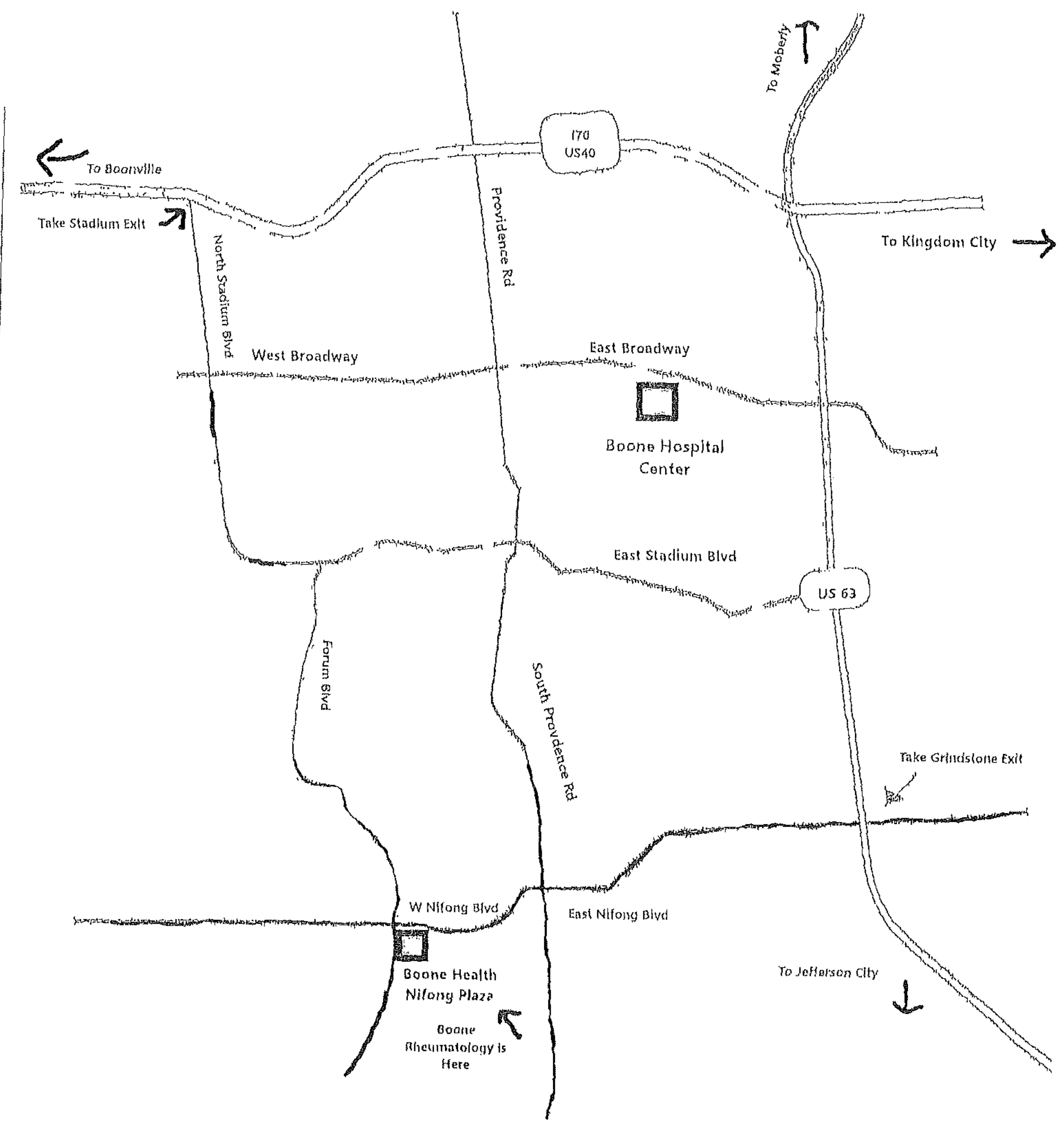
By signing below, I opt-out of sharing my patient information with MHC.

Click here to sign
____
Patient Signature

If Under 18 years, signature of Parent or Guardian

Click here to sign
___________________ ___________________
Legal Representative Name **Relationship**

____
Phone #


To Moberly
I70
US40
To Boonville
Take Stadium Exit
To Kingdom City
Providence Rd
North Stadium Blvd
West Broadway
East Broadway
Boone Hospital
Center
East Stadium Blvd
US 63
Forum Blvd
South Providence Rd
Take Grindstone Exit
W Nifong Blvd
East Nifong Blvd
Boone Health
Nifong Plaza
To Jefferson City
Boone
Rheumatology is
Here