ROBERT W. LEVIN M.D., P.A.

Rheumatology

1831 North Belcher Road, Suite D2 **Telephone: (727) 734-6631**
Clearwater, FL 33765 **Facsimile: (727) 736-0548**

Dear: ________________________________

Welcome to our office. We have you scheduled for an appointment on / / at ____________. At the time of your appointment it is ***VERY IMPORTANT*** for the treatment of your problems that **YOU BRING ALL** pertinent lab work, MRI films, CT scans, Dexa report and scans, xray films and reports. The last page of this questionnaire is a release of records form you may use to help obtain your records from your other doctors.

If you have any problems or questions please feel free to call us at (727) 734-6631.

We look forward to seeing you soon.

Dr. Robert Levin, Karen Duclon, ARNP and Staff

INSURANCE AND DISABILITY FORMS

DUE TO THE COMPLEXITY AND

TIME CONSUMING NATURE OF

INSURANCE / DISABILITY

FORMS AND LETTERS NEEDED

TO BE COMPLETED BY DR. LEVIN

AND KAREN DUCLON, A.R.N.P.

IT MAY TAKE UP TO 8 WEEKS FOR COMPLETION. A FEE WILL APPLY.

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Date of First Appointment ________/________/________ Appt Time ______________________
Month Day Year

Name: ____ Birthdate: ________________
Last First MI

Address: ____ Home Phone:________________
Street Apt.#

____ Cell:________________
City State Zip

Sex: _______M_______F SS#_______________________________ Work:________________

Referred By: ____

Primary Care Dr.:____________________ Phone: ______________ Fax:________________

Describe briefly your present symptoms:

____

____

____

____

Date symptoms began (approximate) ____

Diagnosis given: (please list) ____

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:

____

____

____

RHEUMATOLOGIC (ARTHRITIS) HISTORY:

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

If Yourself	If Relative / relationship	If Yourself	If Relative / relationship
____ Arthritis (type unknown)	____________________	____Lupus	____________________
____ Osteoarthritis	____________________	____ Ankylosing Spondylitis	____________________
____ Rheumatoid Arthritis	____________________	____ Childhood Arthritis	____________________
____ Gout	____________________	____ Osteoporosis	____________________
____ Psoriasis	____________________	____ Psoriatic Arthritis	____________________
____ Ulcerative Colitis	____________________	____ Crohn's Disease	____________________

____ Other ____

HOME CONDITIONS:

Do you have stairs to climb? _______ If yes, how many? ______

Who do you live with? ____

Who does most of the housework? ______________ Who does most of the shopping? _____________

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

Occupation____

Number of hours worked/average per week__________________________

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?			
Dressing yourself?			
Going to sleep?			
Staying asleep due to pain?			
Obtaining restful sleep?			
Breathing?			
Eating?			
Working?			
Getting along with other family members?			
In your sexual relationship?			
Engaging in leisure time activities?			
With morning stiffness?			

Do you use a cane, crutches, walker or wheelchair?____

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

PAST PERSONAL HISTORY:

Do you or have you had: (if yes, please put date diagnosed)

______ Thyroid Problem (hypo or hyper)
______ Stroke
______ Bad Headaches
______ Asthma
______ Heart Problems (type)____________
______ High Cholesterol
______ Pneumonia
______ Epilepsy
______ Cancer (type)____________
______ Liver Disease
______ Stomach Ulcers
______ Diabetes (type 1 0r 2)____
______ Kidney Disease
______ Bowel Disease
______ Rheumatic Fever
______Depression
______ High Blood Pressure
______ Chronic Bronchitis / Emphysema

Other significant illnesses (please list) ____

____

SURGERY:

TYPE YEAR

1.____
2.____
3.____
4.____
5.____
6.____

Any previous fractures? ____Yes ____ No Describe ________________________________

Any other serious injuries? ____ Yes ____ No Describe ________________________________

Any Worker's Compensation Claim? ____Yes ____ No Describe ___________________________

Any injury in a motor vehicle accident? ____ Yes ___No Describe ________________________

FAMILY HISTORY:

	Age	Health	Age at Death	Cause of Death
Father:				
Mother:				

Number of brothers _______ Number living ______ Number deceased ______________

Number of sisters _______ Number living ______ Number deceased ______________

Number of children _______ Number living ______ Number deceased ___________ Ages___________

Serious illnesses of children: ____

____

Do you know of any relative who has or had: (check and relationship)

__________ Cancer
__________ Leukemia
__________ Stroke
__________ Colitis
__________ Heart Disease
__________ Epilepsy
__________ Bleeding tendency
__________ High Blood Pressure
__________ Rheumatic Fever
__________ Tuberculosis
__________ Diabetes
__________ Asthma

MARITAL STATUS:

____ Never Married ____Married ____Divorced ____ Separated ____Widowed

Spouse – Age if alive? ______ Age when deceased? ________

Any major illnesses?____

SYSTEMS REVIEW

As you review the following list, please check any of the problems that apply to you.

GENERAL:
___Recent weight gain/amount
___Recent weight loss/amount
___Fatigue
___Weakness
___Fever

NERVOUS SYSTEM:
___Headaches
___Dizziness
___Fainting
___Muscle spasm
___Loss of consciousness
___Memory loss
___Numbness or tingling in extremities
___Seizures

EARS:
___Ringing in ears
___Loss of hearing

EYES:
___Pain
___Redness
___Loss of vision
___Blurred vision
___Dryness
___Double vision

NOSE:
___Nosebleeds
___Loss of smell
___Dryness
___Ulceration

MOUTH:
___Sore Tongue
___Bleeding gums
___Sores in mouth
___Dryness

THROAT:
___Frequent sore throats
___Hoarseness

NECK:
___Swollen glands
___Tender glands

HEART & LUNGS:
___Pain in chest
___Irregular heart beat
___Sudden changes in hear beat
___Shortness of breath
___Swollen legs or feet
___High blood pressure
___Cough
___Coughing up blood
___Sputum production
___Wheezing
___Night sweats

STOMACH & INTESTINES:
___Nausea
___Vomiting
___Abdominal pain
___Yellow jaundice
___Constipation
___Diarrhea
___Blood in stools
___Black stools
___Heartburn
___Change in bowel habit
___Difficulty swallowing

KIDNEY/URINE/BLADDER
___Difficult urination
___Pain or burning on urination
___Blood in urine
___Cloudy of “smoky” urine
___Frequent urination
___Getting up at night to pass urine
___Discharge from penis/vagina
___Vaginal dryness
___Sexual difficulties
___Prostate trouble

MENSTRUAL:
Age when periods began: ____
Periods regular: ____Yes ___No
How many days apart? _______
Date of last period: __________
Date of last Pap smear: _______
Bleeding after menopause?
___Yes ___No

BLOOD:
___Anemia
___Bleeding tendency

SKIN:
___Easy bruising
___Redness
___Rash
___Hives
___Sun sensitive (sun allergy)
___Tightness
___Nodules/Bumps
___Hair loss
___Color changes of hands or feet in the cold

MUSCLES/JONTS/BONES:
___Morning stiffness lasting how long?
___Minutes
___Hours
___Joint pain
___Muscle weakness
___Muscle tenderness
___Joint swelling
List joints affected in the last six months:
____
____
____
____
____
____
____

HABITS:
Do you smoke?__Yes_No__Past
___ Cigarettes per day
How many alcoholic drinks per week do you have?____
Recreational Drug use? ___
Do you get enough sleep at night? ___Yes ___No
Do you wake up feeling rested?
___Yes ___No

MEDICATIONS:

Drug Allergies _____Yes _____No   If yes, to what? ____________________________________
____
____

Type of reaction: ____
____
____

Present: List any medications you are taking at this time. Include such items as aspirin, Tylenol, ibuprofen, naproxen sodium, vitamins, laxatives and all supplements.

NAME OF DRUG	DOSE (strength & quantity)	For how long?	Please check: Helped? A lot	Some	Not at all
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

Past: 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.

DRUG NAME	DOSAGE	LENGTH OF TIME	RESULTS GOOD FAIR POOR	ALERGIC REACTIONS
1. ASPIRIN				
2. VIOXX				
3. CELEBREX				
4. BEXTRA				
5. MOBIC				
6. TYLENOL				
7. IBUPROFEN / ADVIL				
8. NAPROXEN / ALEVE				
9. ENBREL				
10. HUMIRA				
11. REMICADE				
12. RITUXAN				
13. METHOTREXATE				
14. PREDNISONE / CORTICOSTEROID				
15. ULTRAM / TRAMADOL / ULTRACET				
16. DARVON / DARVOCET PROPOXAPHENE				
17. HYDROCODONE VICODEN/LORTAB				
18. OXYCODONE / PERCOCET				
19. DURAGESIC				
20. OXYCONTIN				
22. METHADONE				
23. INDOCIN				
24. COLCHICINE				
25. ALLOPURINOL				
24. PLAQUENIL				
26. IMURAN / AZATHIOPRINE				
27. RELAFEN / NABUMATONE				
28. LODINE / ETODOLAC				
29. VOLTAREN / DICLOFENAC				
30. ARAVA				
31. CYCLOSPORINE / NEORAL				
32. AZULFADINE / SULFASALAZINE				
33. FOSAMAX				
34. ACTONEL				
35. BONIVA				
36. RECLAST				

AUTHORIZATION FOR RELEASE OF RECORDS

NAME ____ **DATE**______________

DATE OF BIRTH __________________________ **SS#** ___________________________

ADDRESS ____

____

I hereby authorize ___________________________________ (physician) to furnish the requested information from my medical records to:

Robert Levin, M.D.
1831 N. Belcher Rd, Suite D2
Clearwater, FL 33765
Phone: (727) 734-6631
Fax: (727) 736-0548

This will release you and Robert Levin, M.D. ,P.A. from all legal liability that may arise as a result of the release of this information.

Records requested:

______ Recent Office Notes
______ Labs
______ Xray
______ MRI
______ CT
______ Dexa
______ Hospital Records
______ Other

____ ________________

Signature of patient or parent, if minor, or legal guardian **Date**