Dr. Priyanka Jalandhara

1650 W. Rosedale St. Suite 301, Fort Worth TX 76104

(P) 817-259-4333 (F) 817-820-4343

Patient Information

Patient Name:_____ DOB:_____
Last First M.I.

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phn:_____ Cell Phn:_____ Alt. Phn:_____

Emergency Contact: _____ Phone#: _____Relationship _____

SSN:_____ Email:_____

Marital Status: (Circle one) Married Single Divorced Widow Partner Legally Separated

Email Address: _____

Employer Name:_____ Work Phn:_____

_____ Check here if you have no insurance (Cash Account)

Insurance #1:_____ Insured DOB:_____

Insurance #2:_____ Insured DOB:_____

I, the undersigned, hereby authorize payment directly to PPG Healthcare for medical services rendered. I understand I am financially responsible for all charges not covered or authorzed by my insurance company. I also understand that I am responsible for a fee of $ 25.00 for not showing up for the scheduled appointment.

Printed Name:_____

Signature:_____**Date:**_____

** Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.

Dr. Priyanka Jalandhara

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Acknowledgement of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) patients have certain rights to privacy regarding their protected health information. Your protected health information will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Premier Surgical Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waved your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Premier Surgical Associates has previously released relying on this consent.

Print Patient Name:_____

Do we have permission to:

1. Leave a message at your home regarding appointments and/or treatments?..... ___Yes ___No
2. Leave a message at your place of employment regarding appointments/treatments?..... ___Yes ___No
3. Leave a name and call back number at your home and place of employment?.....___Yes ___No
4. Mail test results and appointment information to your home address currently on file? ___Yes ___No
5. Email at filed email address regarding appointments and treatments?..... ___Yes ___No
6. Discuss your personal information, including appointments and treatments with someone other than yourself? ……..... ___Yes ___No

Name	Relationship	Contact Number

Patient Signature:_____ **Date:**_____

Authorization to Release Healthcare Information

Patient Name:_____DOB:_____

SSN:_____ Previous Name:_____

I request and Authorize: _____

(Name of Clinic/Practice/Physician)

To release the medical records of the person named above to:

Name: _____Dr. Priyanka Jalandhara_____

Address: _____1650 W Rosedale, Suite 301_____

City: _____Fort Worth_____ State: __TX_____ Zip Code:___76104_____

Phone:817-259-4333____ Fax: 817-820-0303_____

This request and authorization applies to:

____ All healthcare information

____ Other:_____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus,) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

Signature:_____ Date:_____

_____

Relationship if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Physician List

Patient Name:_____DOB:_____

Physician/Specialist Address:	**Phone & Fax Number:**
_____ Primary Care Physician	_____ Primary Care Physician
_____ Cardiologist	_____ Cardiologist
_____ Pulmonologist	_____ Pulmonologist
_____ Endocrinologist	_____ Endocrinologist
_____ Neurologist	_____ Neurologist
_____ Gastroenterologist	_____ Gastroenterologist
_____ Hematologist	_____ Hematologist
_____ Urologist	_____ Urologist
_____ Other	_____ Other

Medication List

Patients Name:_____ DOB:_____

Pharmacy:_____Phone:_____

Allergies:_____

Medication Name	Dose	Directions

Review of Systems

Name:_____ DOB:_____

Do you now or have ever had any problems related to the following systems in the last month:

Constiutional Sympotoms:
- ☐ Chills
- ☐ Recent Weight Gain
- ☐ Recent Weight loss

Gastrointesthal:
- ☐ Nausea
- ☐ Abdomnial Pain
- ☐ Indigestion

Endrcrine:
- ☐ Excessive Thirst
- ☐ Tired / Slugging

Skin:
- ☐ Easy Brusing
- ☐ Dry Skin
- ☐ Hair Loss

Genitourinary:
- ☐ Painful Urination
- ☐ Genital Rash /Ulcer
- ☐ Sexual Difficulties

Hematologic / Lymphatic:
- ☐ Blood Clot Requiring blood thinner
- ☐ Aenmia

Cardiology:
- ☐ Heart Murmurs
- ☐ Swollen Legs at night

Respiratory:
- ☐ Wheezing
- ☐ Coughing

Musculoskeltal:
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Morning Stiffness

Allergic / Immunologic:
- ☐ Frequent sneezing
- ☐ Itcy eyes

Eyes:
- ☐ Redness
- ☐ Dry eyes
- ☐ Wear glasses / contracts

Ear / Nose / Mouth/ Throat:
- ☐ Sore throat
- ☐ Runny nose
- ☐ Dry mouth

Neurological:
- ☐ Numbness
- ☐ Tinging
- ☐ Dizziness

Psychiatric:
- ☐ Depression
- ☐ Anxiety

Please list all the disease or conditions that you are currently being treated for:

1._____ 2._____ 3._____
4._____ 5._____ 6. _____
7._____ 8._____ 9._____

Did you have any other medical orphychological in past?_____
Do you have Rheumatoid Arthritis? Yes No if no, skip the part below.
If yes, please circle all the medications that you have taken, currently and in the past, and place the date started next to the following below.

Oral

Methotrexate_____
Hydroxychloroquine(plaqunill)_____
Leflunomide(arava)_____
Minocycline_____
Azathloprine_____

Self-injections

Adalimumab(humira)_____
Etanercapt(enbrel)_____
Cartolizumab(cimzia)_____
Golimumab(simponi)_____
Abatacept(orencia)_____

Infusions

Infliximab(remicade)_____
Golimumab(simponi aria)_____
Abatacept(orencia)_____
Tocilizumab(actemra)_____
Rituximab(ritumax)_____

Patient Medical History Questionnaire

Name:_____ DOB:_____

Surgeries:

	Date/Year	Surgeon Name	Nature of Surgery
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Hospitalizations:

	Date/Year	Hospital Name	Reason for Hospitalization
1.			
2.			
3.			
4.			
5.			

Please CIRCLE your answer below:

Flu Shot: Y N Date Received:_____

Pneumococcal Vaccine: Y N Date Received:_____

Patient Medical History Questionnaire Page 2

Family History:
Please make a check in the boxes that apply:

	Status: A=Alive D=Deceased	Osteoarthritis	Rheumatoid Arhrthritis	Gout	SLE/Lupes	Other Tissue Disease
Mother	A D					
Father	A D					
Paternal Grandfather	A D					
Paternal Grandmother	A D					
Maternal Grandfather	A D					
Maternal Grandmother	A D					
Brother(s)(__)	A D					
Sister(s)(__)	A D					
Sons(s)(__)	A D					
Daughter(s)(__)	A D					

Social History:

	Current Use	Frequency	If use, When?
Smoking			
Alcohol			
Illicit Drug Use			

Patient Identification

This questionable includes information not available from blood test, x-ray, or any source other then you. Please try to answer each question, if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you

1. **Please check the ONE best answer for your abilities at this time: OVER THE LAST WEEK, were you able to:**

	Without ANY Difficuly	With SOME Difficuly	With MUCH Difficuly	UNABLE to do
a. Dress yourself, including tying shoelaces and buttons?	_____ 0	_____ 1	_____ 2	_____ 3
b. Get in and out of bed?	_____ 0	_____ 1	_____ 2	_____ 3
c. Lift a full cup or glass to your mouth?	_____ 0	_____ 1	_____ 2	_____ 3
d. Walk outdoors on felt ground?	_____ 0	_____ 1	_____ 2	_____ 3
e. Wash and dry your entire body?	_____ 0	_____ 1	_____ 2	_____ 3
f. Bend down to pick up clothing from the floor?	_____ 0	_____ 1	_____ 2	_____ 3
g. Turn regular fauats on and off?	_____ 0	_____ 1	_____ 2	_____ 3
h. Get in and out of a car, bus, train or airplane?	_____ 0	_____ 1	_____ 2	_____ 3
i. Walk two miles or three kilometer, if you wish?	_____ 0	_____ 1	_____ 2	_____ 3
j. Participate in recreation activities and sports as you would like, if you wish?	_____ 0	_____ 1	_____ 2	_____ 3

2. How much pain have you have you had because of your condition OVER THE PAST WEEK?

Please indicate below how severe your pain has been:

NO O O O O O O O O O O O O O O O O O O O O **PAIN BAD AS**

PAIN 0 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 **IT COULD BE**

3. Considering all ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY O O O O O O O O O O O O O O O O O O O O **VERY**

WELL 0 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 **POORLY**

FOR OFFICE USE ONLY

1.a-j FN(0-10)

1=0.9	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=0.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN(0-10)

3.PTGL(0-10)

RAPID 3(0-30)

CAT:
HS=>12
MS=6.0-12
LS=3.1-6
R=53

_____
SIGNATURE

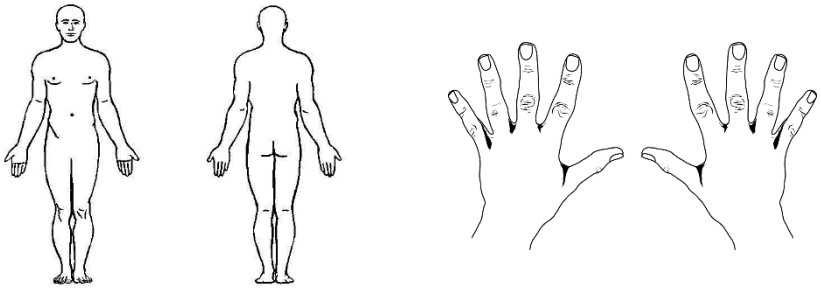
_____
DATE

_____
TIME

Patient Identification Page 2

History of present illness (describe your problem in detail)
Please answer each of the following 10 question:

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



1. Location of the problems
   - ☐ All my joint
   - ☐ All my muscles
   - ☐ R / L Elbow
   - ☐ Head
   - ☐ R / L hip
   - ☐ R / L Calve
   - ☐ R / L Shoulder
   - ☐ Scalp
   - ☐ Neck
   - ☐ Face
   - ☐ R / L Knee
   - ☐ R / L Thigh
   - ☐ R / L Hand
   - ☐ R / L Ankle
   - ☐ Upper / middle / lower back
   - ☐ Other_____

2. On the scale of 1-10, with 10 being the most severe, circle the number that best describes the problem

   0 1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem?
   ☐ 2 days ago ☐ 2 weeks ago ☐ 1 month ago ☐ 1 year ago ☐ 5 years ago
   ☐ Other _____
4. How long does the problem the worst?
   ☐ 5-15 minutes ☐ 16-30 minutes ☐ 31-59 minutes ☐ 1-2 hours ☐ Always there
   ☐ Other _____
5. When is the problem the worst?
   ☐ No relation to any specific time ☐ Night ☐ Morning ☐ Noon ☐ Afternoon
   ☐ Other _____
6. Does anything make the problem worst? Y N
   If yes, please explain: ☐ Moving around ☐ Walking ☐ Sitting ☐ Standing up ☐ Driving
   ☐ Lying on my side ☐ Other _____
7. Dose anything help or make the problem better? Y N
   If yes, please explain: _____
8. Is anything else occurring at the same time? Y N
   If yes, please explain: ☐ Nausea ☐ Rash ☐ Headaches ☐ Fever ☐ Tinging ☐ swelling
   ☐ Stiffness ☐ Other _____
9. Is the problem constant or variable?
   ☐ Dull then sharp ☐ Very sharp then leaves ☐ Dull then throbbing ☐ Constant
   ☐ Other _____
10. Does the problem interfere with your normal functions? Y N
    If yes, please explain: _____