Cheyenne Regional Medical Group
Medical Specialty Clinic

Rheumatology

2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Patient Name _____Date: _____

Provider you will be seeing: _____

PLEASE ARRIVE AT _____FOR YOUR CHECK IN TIME

Appointment Date: _____

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up **AT YOUR CHECK IN TIME** for your appointment so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

Medical Specialty Clinic: Rheumatology

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medication

☐ No Medication

Current Medication	Dosage	Frequency

Allergies

☐ No Allergies ☐ Latex Allergy

Medication / Food / Any Allergies	Reaction

Medical History (Check All That Apply)

- ☐ Alzheimer's Disease
- ☐ Cancer (Type: _____)
- ☐ Stomach Ulcers
- ☐ Depression
- ☐ Heart Attack (Year:_____)
- ☐ High Cholesterol
- ☐ Polio
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Carpal Tunnel
- ☐ Obesity
- ☐ Tuberculosis
- ☐ COPD
- ☐ Genitourinary Disease (Type: _____)
- ☐ Stroke
- ☐ HIV (AIDS)
- ☐ Peripheral Vascular Disease
- ☐ Asthma
- ☐ Blood Disease
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Fracture Spine
- ☐ Spinal Cord Injury
- ☐ Thyroid Disorder
- ☐ Headache, Migraine
- ☐ Parkinson's Disease
- ☐ Peripheral Nerve (Type: _____)
- ☐ Arrhythmia
- ☐ Diabetes
- ☐ Sexually Transmitted Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Fracture Upper Limb
- ☐ Mental Illness
- ☐ Seizure Disorder
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other: _____

Surgical History (Check All That Apply)

- ☐ No Surgery
- ☐ Angioplasty (Year: _____)
- ☐ LASIK (Year: _____)
- ☐ Broken Bones that Require Surgery (Year: _____)
- ☐ Heart Bypass (Year: _____)
- ☐ Knee Replacement (Year: ____)
- ☐ Thyroidectomy (Year: _____)
- ☐ Craniotomy (Year: _____)
- ☐ Colostomy (Year: _____)
- ☐ Lumbar Discectomy (Year: ____)
- ☐ Angioplasty with Stents (Year: _____)
- ☐ Hip Replacement (Year: _____)
- ☐ Spinal Fusion (Year: _____)
- ☐ Cervical Discectomy (Year: ____)
- ☐ Liver Biopsy (Year: _____)
- ☐ Arthroscopy Knee (Year: _____)
- ☐ Hernia Repair (Year: _____)
- ☐ Small Bowel (Year: _____)
- ☐ Cataract Extraction (Year: ____)
- ☐ Laminotomy (Year: _____)
- ☐ Arthrodesis (Year: _____)
- ☐ Gastric Bypass (Year: _____)
- ☐ Pacemaker (Year: _____)
- ☐ Carpal Tunnel Release (Year: _____)
- ☐ Laminectomy (Year: _____)
- ☐ Colectomy (Year: _____)
- ☐ Breast Implants (Year: _____)
- ☐ Breast Biopsy (Year: _____)
- ☐ D&C (Year: _____)
- ☐ Mastectomy (Year: _____)
- ☐ Breast Reduction (Year: _____)
- ☐ Vaginal Hysterectomy (Year: _____)
- ☐ Total Hysterectomy (Year: ____)
- ☐ Tubal Ligation (Year: _____)
- ☐ C-Section (Year: _____)
- ☐ Myomectomy (Year: _____)
- ☐ Prostate Biopsy (Year: _____)
- ☐ Vasectomy (Year: _____)
- ☐ TURP (Year: _____)
- ☐ Other: _____ _____

Advanced Directives

Do You Have Advanced Directives: NO YES
Do You Have a Living Will: NO YES
Do You Have a Healthcare Proxy: NO YES
Do You Have a Do Not Resuscitate Order: NO YES
Do You Have a Designated Durable Power of Attorney for Health Care: NO YES If Yes, Their Name: _____

Social History

Do You Use Tobacco: Never / Former (Quit Date :_____) / Yes (Type: _____ How many packs per day? _____)
Do You Drink Caffeine: NO YES (Type: _____ Amount Daily: _____)
Do You Drink Alcohol: NO / Former / YES (Type: _____ Amount: _____
How Much Per Week: _____ Date of Last Drink: _____)

Family History

Place a check under the relative(s) that had the below condition. If the condition was the cause of death, please place an * under the family member.

☐ Adopted
☐ All Family Members are Alive and Well

Condition	Mother	Father	Sister	Brother	Other Relative (Please List)
Alcohol Abuse					
Arthritis					
Asthma					
Birth Defects					
Cancer					
COPD					
Depression					
Diabetes					
Drug Abuse					
Early Death					
Hearing Loss					
Heart Disease					
Hyperlipidemia					
Kidney Disease					
Learning Disabilities					
Mental Illness					
Mental Retardation					
Miscarriages / Stillborn					
Stroke					
Vision Loss					
Polio					

Review of Symptoms (Check All That Apply)

Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Excessive Sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Change

HENT
- ☐ Congestion
- ☐ Dental Problem
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nose Bleed
- ☐ Postnasal Drip
- ☐ Excessive Mucus
- ☐ Sinus Pain
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Trouble Swallowing
- ☐ Voice Change

Skin
- ☐ Color Change
- ☐ Pale Skin
- ☐ Rash
- ☐ Wound

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Extreme Light Sensitivity
- ☐ Visual Disturbance

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Harsh Vibrating Noise When Breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

Gastroenterology
- ☐ Abdominal Distention
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Large Volume of Urine

Genitourinary
- ☐ Difficulty Urinating
- ☐ Painful Intercourse
- ☐ Painful or Difficult Urination
- ☐ Involuntary Urination
- ☐ Flank Pain
- ☐ Frequency
- ☐ Genital Sores
- ☐ Blood in Urine
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Urgency
- ☐ Urine Decreased
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Joint Pain
- ☐ Back Problems
- ☐ Trouble Walking
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Neck Stiffness

Allergy
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurological
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headaches
- ☐ Light-headedness

Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Loss of Consciousness
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Swollen Lymph Nodes
- ☐ Bruise / Bleed Easily

Psychiatric
- ☐ Agitation
- ☐ Behavior Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Depressed
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous / Anxious
- ☐ Self-Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Ideas

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CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE

Dear Valued Patient,
Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all our patients.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENT
To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist, you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

LATE CANCELLATION
A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

NO-SHOW PROCEDURE
A "no-show" is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

- First no show: There will be no charge
- Second no show: May result in a $25 fee billed to your account
- Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Today's Date

The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process.