

PINNACLE MEDICAL GROUP

Rheumatology

Brian T. McKinley, M.D.

315 75th Street West • Bradenton, FL 34209 • 941-792-8329

PATIENT INFORMATION

Please Print and Complete All Blanks

Name: _____

Address: _____ City _____ State: _____ Zip: _____

Home Phone: _____ DOB: _____ Age: _____ Sex: Male Female

SSN#: _____ Marital Status: _____

Email: _____

Ethnicity: _____ Preferred Language: _____

Race: American Indian or Alaska Native Black or African American Asian

Native Hawaiian or Other Pacific Islander Unreported/Refused to Report White

Employer's Name/Address: _____

Employer's Phone: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer's Phone: _____

Spouse's DOB: _____ Spouse's SSN#: _____

OUT OF STATE ADDRESS (if applicable)

Address: _____ City _____ State: _____ Zip: _____

Home Phone: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____

Address: _____ City _____ State: _____ Zip: _____

Home Phone: _____

EMERGENCY CONTACT

Name: _____ Home Phone: _____

OTHER DOCTORS

Referring Physician _____ PCP: _____

OFFICE POLICY FOR MEDICATION REFILLS

1. Medications will only be renewed when due, based on the proper schedule of usage. No early refills will be provided under any circumstances (whether lost, stolen, destroyed, etc.)
2. It is your responsibility to anticipate the need for refills; they will not be provided if the office is closed. Office hours are: Monday - Thursday 9 am - 5 pm, Friday 9 am - 12 pm.
3. This office will not prescribe controlled medications for pain, sleep, anxiety, or depression if you are already receiving them from other physicians.
4. When controlled medications for pain, sleep, anxiety, or depression are prescribed by this office, seeking other sources (walk-in clinics, emergency rooms, other physicians, etc.) without notifying this office is unacceptable.
5. Please provide 24 hours for our office to get your prescription ready.
6. Provide the pharmacy and location you be using with this office: _____

THE ABOVE RULES CONSTITUTE AN AGREEMENT BETWEEN YOU AND THIS OFFICE AND ANY VIOLATION MAY RESULT IN YOUR DISCHARGE.

Patient Signature: _____ Date: _____

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Physician Review

Patient Name: _____ Date: _____

Please check the one best answer for your abilities. At this moment, you are able to:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	Unable to do
1. Dress yourself, including tying shoe laces & doing buttons?				
2. Get in and out of bed?				
3. Lift a full cup or glass to your mouth?				
4. Walk outdoors on flat ground?				
5. Wash and dry your entire body?				
6. Bend down to pick up clothing from the floor?				
7. Turn regular faucets on and off?				
8. Get in and out of a car, bus, train or airplane?				

1. When you get up in the morning, do you feel stiff? Yes No
2. If you answered "Yes", how long? _____ Min. or _____ Hrs.
3. Do you get enough sleep at night? Yes No
4. Do you wake feeling rested? Yes No
5. Rate your arthritis pain over the past week? Select a number below.

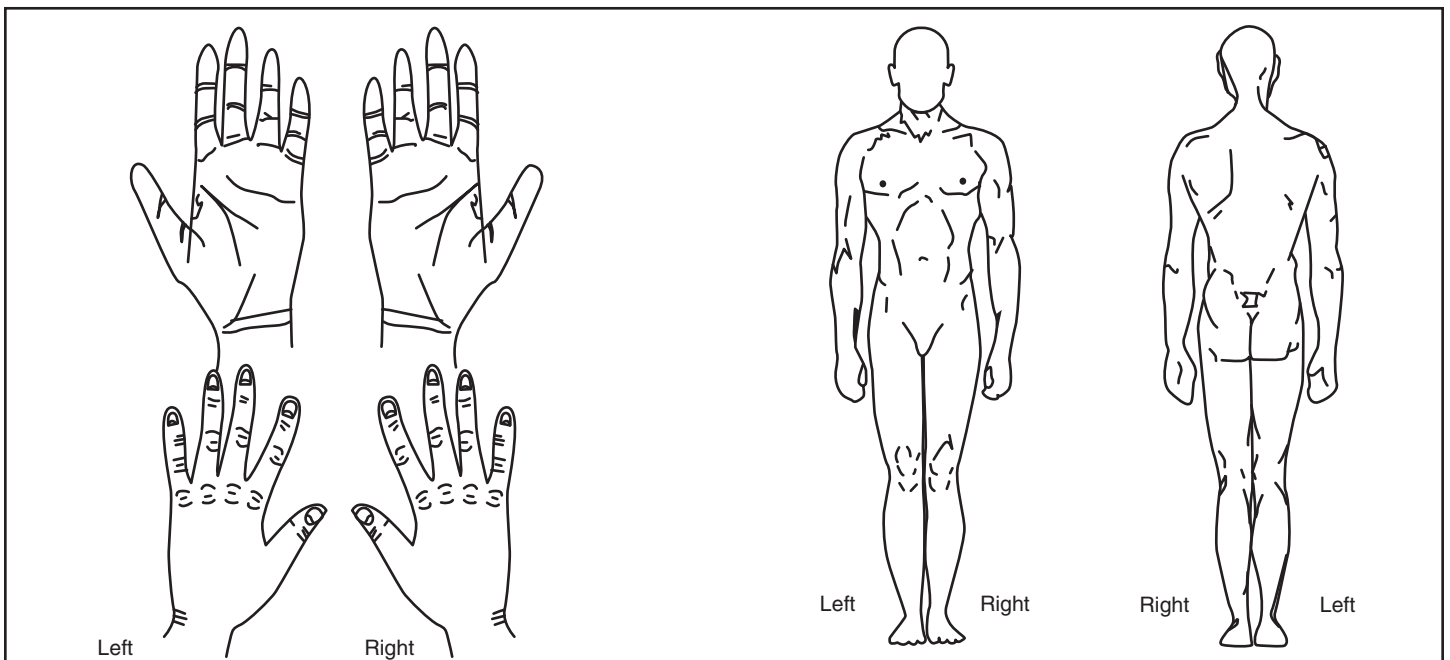
(No pain)

(Worst pain)

1 2 3 4 5 6 7 8 9 10

Doctor Use Only

Meds-	Reviewed/updated
	Not addressed
PMH-	Reviewed/updated
	No Change
	Not addressed



PATIENT HISTORY AND PHYSICAL

Physician Review

Name: _____ Age: _____ Date: _____

Referring Physicians: _____ Primary Physician _____

PAST MEDICAL HISTORY:

Please check all that apply for your *personal* medical history

- | | |
|--|---|
| <input type="checkbox"/> Heart disease/heart attack | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Prior stomach ulcer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Fracture(s) - location |
| <input type="checkbox"/> Cancers | |
| <input type="checkbox"/> Others (Please List): _____ | |

SURGERIES:

- Orthopedic or joint replacements _____
- Other surgeries _____

SOCIAL HISTORY:

Occupation (Past/Present): _____

Retired: No Yes

Alcohol: No Yes If "Yes", _____ drinks per _____

Tobacco: No Yes If "Yes", packs per day? _____

Quite date _____

Recreational Drugs: Never Current Prior _____

FAMILY HISTORY:

- Arthritis: _____
- Autoimmune disease (lupis/Sjogrens/etc): _____
- Other: _____

PATIENT HISTORY AND PHYSICAL

DO YOU EXPERIENCE:

Please check all that apply.

- Non-restful sleep
- Fatigue
- Fevers
- Recurrent infections
- Weight change over last year
 - Increase: _____ lbs.
 - Decrease: _____ lbs.
- Red/tender/dry eyes
- Dry mouth
- Oral ulcers
- Swollen lymph
- Chest pain
- Palpitations/irregular heartbeat
- Chest pain with deep breathing
- Cough: Productive Dry
- Nausea/vomiting/abdominal pain
- Indigestion/heartburn
- Difficulty swallowing:
 - Solids Liquids
- Diarrhea: Frequent Rare
 - Diet related
- Constipation:
 - Frequent Rare
- Headaches:
 - Frequent Rare
- History of abrupt loss of vision
- Jaw pain when chewing
- Scalp tenderness
- Loss of sensation/numbness
 - Arm - Right Left
 - Leg - Right Left
- Weakness
 - Arm - Right Left
 - Leg - Right Left
 - All over
- Hallucinations
- Blackouts/seizures
- Rash/skin changes
- Blue/white skin color changes in the cold
 - Fingers
 - Toes
- Hair loss with bald spot
- Blood Disorder

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Physician Review

PATIENT RESPONSIBILITY FOR TAKING CONTROLLED SUBSTANCES

(Medications for sleep, pain, and depression)

- 1. List all of this type of medication you have taken in the last 6 months along with prescribing doctor and pharmacy.

Drug	Dose	Doctor	Pharmacy

- 2. I understand that prescriptions for controlled substances will only be written if I am NOT receiving them from other doctors (unless prescribing responsibility is formally transferred).
- 3. My medications will only be renewed when due, based on the proper schedule of usage. If my medication is stolen. I must report this to the police and provide Pinnacle Medical Group with a copy of their report before a substitute prescription will be provided.
- 4. I understand that seeking other sources for these medications (walk-in clinics, emergency rooms, other doctors, etc.) is NOT acceptable unless for a different unrelated medical condition. I will speak with my prescribing doctor BEFORE any changes are made in medication doses or frequency.
- 5. It is my responsibility to anticipate the need for refills; they will NOT be provided when the office is closed. Office hours are Monday - Thursday 9:00 am to 12:30 pm and 1:30 pm to 5:00 pm, Friday 9:00 am to 12:30 pm. Please allow 24 hours for refill requests.
- 6. Provide the pharmacy and location you will be using with this office:

I UNDERSTAND THE ABOVE RULES CONSTITUTE AN AGREEMENT BETWEEN MYSELF AND PINNACLE MEDICAL GROUP AND ANY VIOLATION MAY RESULT IN MY DISCHARGE.

Signed _____ Date _____

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**Patient Consent to Receive Mail, Telephone
and/or E-mail Message**

DOB: _____

Please print (Last Name) (First Name) (M.I.)

Do we have permission to?

Send a yearly appointment card to your home? Yes No

Send test results to your home? Yes No

Send test results to your email? Yes No

Email address: _____

Leave the following information on your home answering machine/voice mail/email:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

Leave the following information on your work answering machine/voice mail:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: _____

Name: _____

I give permission to share billing information with the person listed below:

Name: _____

Signature of Patient: _____ Date: _____

For internal purposes only - Account No: