

Rheumatology

Brian T. McKinley, M.D.

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

Patient Name: _____ Date: _____

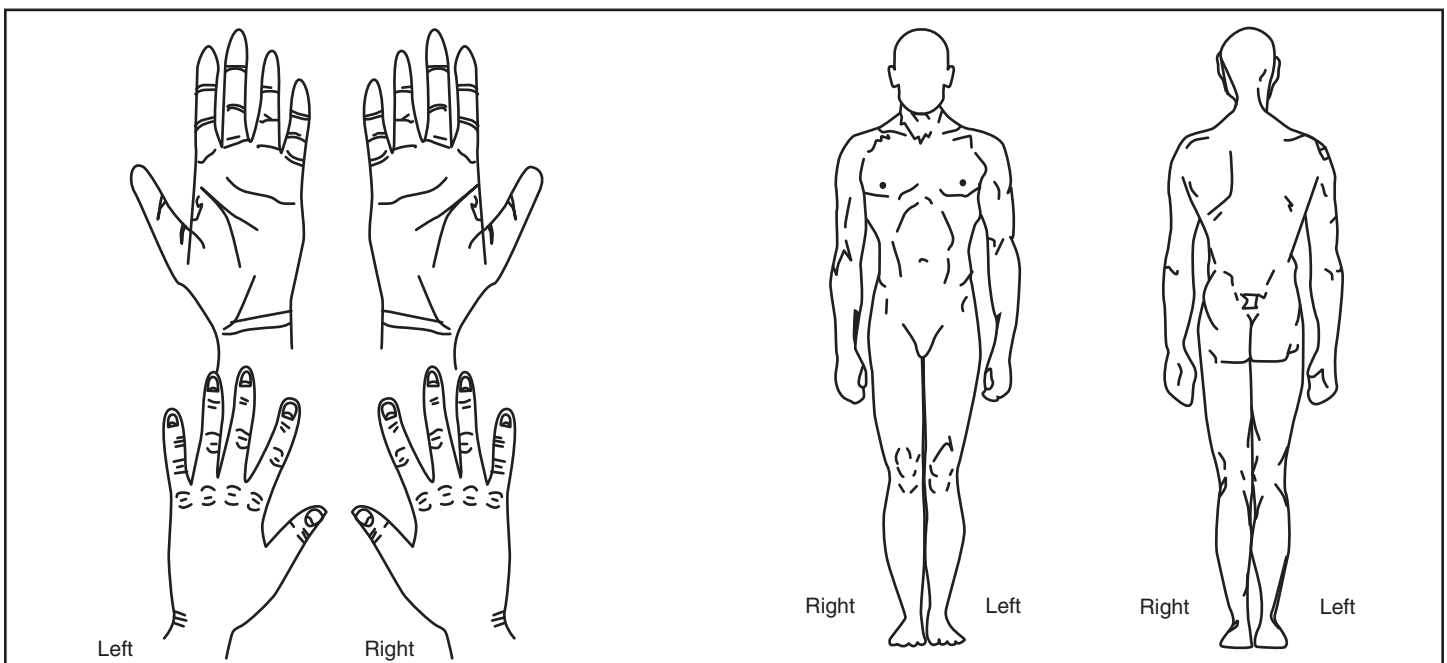
Please check the one best answer for your abilities. At this moment, you are able to:

	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 is it until you are as limber as you will be for that day? _____ Min. or _____ Hrs.
3. Do you get enough sleep at night? Yes No
4. Do you wake feeling rested? Yes No
5. How much pain have you had because of your condition over the past week?



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





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PATIENT HISTORY AND PHYSICAL

Patient Name: _____ Date: _____

SOCIAL HISTORY:

Occupation (Past/Present): _____

Marital Status: [] Single [] Married [] Divorced [] Widowed [] Children _____

Alcohol: [] Never [] Yes If "Yes" _____ drinks per _____

Quit: [] No [] Yes If "Yes" how many years? _____

Tobacco: [] Never [] Yes If "Yes" packs per day? _____

Quit: [] No [] Yes If "Yes" how many years? _____

Recreational Drugs: [] Never [] Yes If "Yes" [] Oral [] IV

Quit: [] No [] Yes If "Yes" how many years? _____

Coffee: [] Never [] Yes If "Yes" cups per day? _____

FAMILY HISTORY:

Arthritis [] Rheumatoid _____ [] Osteo _____ [] Gout _____

[] Cancer _____

[] Osteoporosis _____ [] High Blood Pressure _____

[] Heart Disease _____ [] Diabetes _____

[] Stroke _____ [] Vasculitis _____

[] Lupus _____ [] Scleroderma _____

[] Polymyalgia Rheumatica _____ [] Sjogrens _____

CURRENT MEDICATION(S):

Table with 2 columns: Name, Dose. Rows 1-10.



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PATIENT HISTORY AND PHYSICAL

Name: _____ Age: _____ Date: _____

Referring Physician: _____ Primary Physician: _____

Allergies: _____

PAST MEDICAL HISTORY:

Please check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gall Bladder Surgery |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Abdominal Surgery |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hernia Surgery |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Peripheral Vascular | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Other – Please list: |
| <input type="checkbox"/> Joint Replacement(s): _____ | _____ |
| _____ | _____ |
| <input type="checkbox"/> Fractures(s): _____ | _____ |
| _____ | _____ |

FEMALE: Last PAP: _____ Result: _____ Last Mamo: _____ Result: _____

Menopause: No Yes Date: _____

Hysterectomy: Partial Complete

Last Dexa/Bone Density: _____

MALE: Last PSA (Prostate Cancer Check): _____ Result: _____

SURGICAL HISTORY:

Date:	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



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PATIENT HISTORY AND PHYSICAL

DO YOU EXPERIENCE:

Please check all that apply

- Non-Restful Sleep Patterns
- Fatigue
- Palpitations/Irrigular Heartbeat
- Fevers
- Chills
- Nausea
- Vomiting
- Indigestion/Heartburn
- Chest Pain
- Abdominal/Stomach Pain
- Rash/Skin Changes
- Rash/Skin Changes Related to Sun Exposure
- Diarrhea: Frequent Rare Diet Related _____
- Red/Tender Eyes
- Blue/White Fingers and/or Toes in Cold Weather Temperatures
- Joint/Muscle Stiffness in the Morning lasting _____ hours
- Swelling in Joints
- Cough: Productive Dry
- Headaches: Frequent Rare
- Loss of Vision
- Jaw Pain when Chewing
- Scalp Tenderness
- Difficulty Swallowing: Solids Liquids
- Weight Loss/Gain in the Past 12 Months
- Seizures
- Dry Eyes and/or Mouth
- Hallucinations
- Blackouts
- Weakness in Arms and/or Legs
- Blood Disorder
- Kidney Disorder/Frequent Urinary Tract Infections
- Loss of Sensation/Numbness
- Hair Loss with Bald Spot
- Chest Pain with Deep Breathing
- Shortness of Breath
- Burning with Urination
- Oral Ulcers



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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 INFORMATION
Please Print and Complete All Blanks

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ DOB: _____ Age: _____ Sex: Male Female
SSN#: _____ Marital Status: _____
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: _____