JOHNS CREEK SPECIALIST CENTER
Tel 678-679-6210
3340 Paddocks Parkway
Fax 678-679-6220
Suwanee, GA 30024

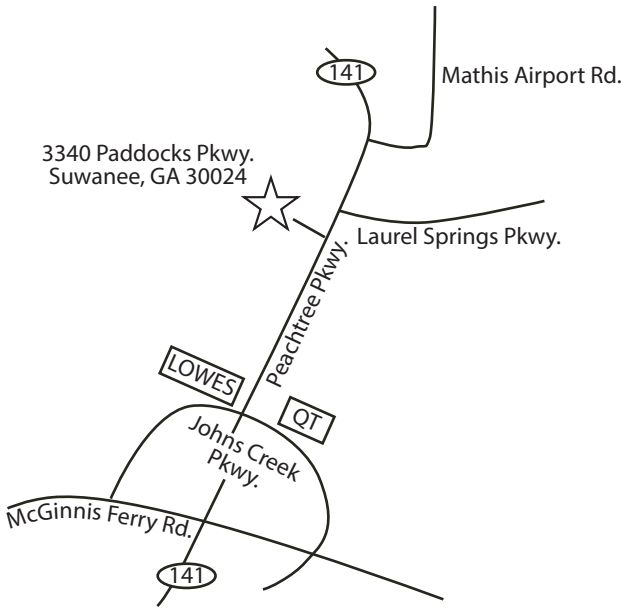
Welcome to John's Creek Specialist Center

We at John's Creek Specialist Center are committed to excellence in healthcare. Our well-trained team is focused on providing a high standard of care in a warm, efficient office environment. We realize that you have a choice regarding your medical care. We appreciate and value your business, and we will strive to do everything we can to provide you with the personalized service you deserve.

Directions

John's Creek Specialist Center is located at 3340 Paddocks Parkway in Suwanee. If this map does not help you with your route to our office, and if you have Internet access, just go to http://maps.google.com, and you can create custom turn-by-turn directions from your location.

If you do not have access to the Internet, or if the resulting directions are not helpful to you, just call our office at 678-679-6210, and we'll be glad to help you with directions.



New patient forms

Please print the forms, fill them out by hand, and bring them with you at the time of your visit.

Thank you for your help!

NEPH 08-11

Reorder #38050 PP0476 (JCSC)
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Answer each line and question in the space provided. Circle/check the best answer. Fill out both sides of this form. This survey will help the doctor evaluate, diagnose and treat you. Write your comments & questions on next page.

Name:_____
Age:_____ Birthdate:___ /___/_____
Email:_____@_____

Date:_____ Referred by:_____
My Primary Care MD:_____
My Primary Care Phone:_____

Emergency Contact: Relationship: Phone#: Work#:

ABOUT YOUR ARTHRITIS OR PROBLEM

What is your problem? _____
Symptoms first began: Month _____ Year _____ Initial symptom(s): _____
Where: ☐ Fingers ☐ Hands ☐ Wrist ☐ Elbow ☐ Shoulder ☐ Knee ☐ Feet ☐ Hip ☐ Back ☐ Neck
First diagnosed as:_____ By Dr._____ Where?_____
What tests were abnormal: ☐ ANA ☐ Sed Rate ☐ RF (rheumatoid factor) ☐ Uric Acid ☐ Biopsy
This week I am doing: ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor ☐ Better ☐ Much Worse
I am mostly concerned about:_____
I am having: ☐ Pain ☐ Stiffness ☐ Aching ☐ Soreness ☐ Muscle pain ☐ Swelling ☐ Weakness ☐ Numbness
How long is your morning stiffness? ☐ None ☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 2 hr ☐ 4 hr ☐ All Day
My sleep is: ☐ Great ☐ Norrnal ☐ Fair ☐ Poor ☐ Very Poor Sleeping aids used? ☐ No ☐ Yes
☐ Can't fall asleep ☐ Can't stay asleep ☐ Early waking ☐ Snoring ☐ Sleep apnea ☐ Restless legs ☐ Pain

In PAST WEEK, how much pain have you had? (circle a number or put a mark thru the line below)

NO PAIN **0 1 2 3 4 5 6 7 8 9 10** *MOST SEVERE PAIN*
Mild Moderate Severe

Medical History				**Past Surgeries**	**Year**
☐ Seizures	☐ Skin problems	☐ Pancreatitis	☐ Osteoporosis	☐ Neck surgery	
☐ Stroke ☐ TIA	☐ Psoriasis	☐ Stomach ulcers	☐ Polymyositis	☐ Back surgery	
☐ Neuropathy	☐ Thyroid problem	☐ Colitis/bowel probs	☐ Scleroderma	☐ Joint replacement	
☐ Depression	☐ Cancer ☐ Chemo	☐ Glaucoma ☐ Cataract	☐ Fibromyalgia	☐ Arthroscopic	
☐ Alcohol abuse	☐ Pneumonia	☐ Accidents ☐ Falls	☐ Lupus	☐ Tonsillectomy	
☐ Hypertension	☐ Lung disease	☐ Miscarriage(s)	☐ Gout	☐ Appendectomy	
☐ Diabetes	☐ Asthma ☐ COPD	☐ Blood clots	☐ Vasculitis	☐ Gall bladder	
☐ Anemia	☐ Tuberculosis	☐ TMJ/jaw problems	☐ Carpal tunnel	☐ Hysterectomy	
☐ Heart attack	☐ (+)TB skin test	☐ Migraine	☐ Sjogren syndrome	☐ Heart bypass	
☐ Heart failure	☐ Gallstones	☐ Sleep apnea	☐ Rotator cuff	☐ Hernia repair	
☐ Irregular heart	☐ Hepatitis	☐ Osteoarthritis	☐ Bursitis ☐ Tendinitis	☐ Breast surgery	
☐ High cholesterol	☐ Kidney stones	☐ Rheumatoid arthritis	☐ Juvenile arthritis	☐ Fracture(s)	
	☐ Kidney disease	☐ Ankylosing Spondylitis	☐ Spine problems		

DO YOU HAVE?				
☐ Weight loss ____ lbs	☐ Bursitis	☐ Eye pain	☐ Swallowing problem	☐ Wheezing
☐ Weight gain ____ lbs	☐ Nodules	☐ "Pink" (red) eyes	☐ Eating disorder	☐ Purple/blue fingers
☐ Fever	☐ Skin rash/sores	☐ Vision problems	☐ Peptic ulcer	☐ Edema in legs/feet
☐ Weakness	☐ Tight skin	☐ Nosebleeds	☐ Gastritis ☐ Reflux	☐ Pain on urination
☐ Fatigue	☐ Hives/welts	☐ Chronic sinusitis	☐ Diarrhea	☐ Bladder problem
☐ Night sweats	☐ Itching	☐ Ringing in ears	☐ Constipation	☐ Vaginal discharge
☐ Joint pains	☐ Hair falling out	☐ Jaw pain	☐ Irritable bowel	☐ Menstrual problem
☐ Morning stiffness	☐ Abnormal nails	☐ Hearing problems	☐ Diverticulitis	☐ Numbness
☐ Pain in muscles	☐ Easy bruising	☐ Swollen glands	☐ Blood in stool	☐ Headaches
☐ Back pain	☐ Sore throat	☐ Poor appetite	☐ Hemorrhoids	☐ Dizzy spells
☐ Heel pain	☐ Sores in mouth	☐ Heartburn	☐ Jaundice	☐ Loss of memory
☐ Tendinitis	☐ Dental problems	☐ Indigestion	☐ Chest pain	☐ Anxiety
	☐ Dry mouth	☐ Nausea	☐ Cough	☐ Depression
	☐ Dry eyes	☐ Vomiting	☐ Short of breath	☐ Difficulty sleeping

What medicine(s) are you allergic to?

List all prescription medications you are now taking (include over the counter meds and natural/herbal pills)

Drug name	Dose	How many times/day	Drug name	Dose	How many times/day
1.			5.		
2.			6.		
3.			7.		
4.			8.		

My preferred pharmacy Pharmacy phone #:

PATIENT SURVEY

Name

HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS? (Check all you have taken)

☐ Antacids	☐ Bextra	☐ Orudis Etodolac	☐ Gold	☐ Cortisone	☐ Buspr Wellbutrin	☐ Vicodin
☐ Axid	☐ Celebrex	☐ Voltaren	☐ Enbrel	☐ Prednisone	☐ Effexor Pristiq	☐ Baclofen
☐ Cytotec	☐ Clinoril	☐ Colchicine	☐ Humira	☐ Ambien	☐ Lexapro	☐ Flexeril
☐ Pepcid	☐ Daypro	☐ Allopurinol	☐ Ilaris	☐ Ativan	☐ Pamelor	☐ Norflex
☐ Prevacid	☐ Disalcid	☐ Uloric Febuxostat	☐ IVIG	☐ Halcion	☐ Paxil	☐ Parafon forte
☐ Prilosec	☐ Dolobid	☐ Krystexxa	☐ Imuran	☐ Klonopin	☐ Prozac	☐ Robaxin
☐ Protonix	☐ Ecotrin	☐ Actemra	☐ Kineret	☐ Lunesta	☐ Savella	☐ Skelaxin
☐ Nexium	☐ Feldene	☐ Arava	☐ Methotrexate	☐ Restoril	☐ Seroquel	☐ Soma
☐ Tagamet	☐ Ibuprofen	☐ Atabrine	☐ Orencia	☐ Valium	☐ Zoloft	☐ Zanaflex
☐ Zantac	☐ Indocin	☐ Auranofin	☐ Otezla	☐ Xanax	☐ Codeine	☐ Cholesterol/Stalins
☐ Advil	☐ Lodine	☐ Azathioprine	☐ Penacillamine	☐ Celexa	☐ Hydrocodone	☐ Flu vaccine
☐ Aleve	☐ Mobic	☐ Azulfidine	☐ Plaquenil	☐ Desyrel	☐ Lortab / Lorcet	☐ Hepatitis vaccine
☐ Anacin	☐ Motrin	☐ Benlysta	☐ Remicade	☐ Elavil	☐ Oxycontin	☐ Pneumovax
☐ Anaprox	☐ Naproxen	☐ Cimzia	☐ Rituxan	☐ Trazodone	☐ Percocet/dan	☐ Shingles vaccine
☐ Ansaid	☐ Relafen	☐ Cosentyx	☐ Simponi	☐ Cymbalta	☐ Tramadol	☐ Tetanus
☐ Arthrotec	☐ Tolectin	☐ Cyclosporine	☐ Sulfasalazine	☐ Lyrica	☐ Tylenol #3	☐ Drug study
☐ Aspirin	☐ Vioxx	☐ Cytoxan	☐ Xeljanz	☐ Neurontin	☐ Ultram/Ultracet	☐ Injections

Have you had side effects from any of these drugs? ☐ No ☐ Yes → (which medicine / what side effect?)

Work / Lifestyle / Family / Habits / Exercise

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who lives with you?_____ How many children?_____

Do you have help at home? ☐ No ☐ Yes → Who:_____

Current Job?_____ Employer_____

Do you Smoke? ☐ Never ☐ No (Quit ____ yrs ago) ☐ Yes → (Packs per day?____)

Do you drink alcohol? ☐ Never ☐ I quit ☐ Rarely ☐ Socially ☐ Daily (_____)

Have you used illegal drugs? ☐ Never ☐ Yes (Which_____)

Is drug/alcohol abuse a problem? ☐ No ☐ Yes → ☐ For ME ☐ My Family

What exercise do you do: ☐ None ☐ Walk ☐ Bike ☐ Pool ☐ Run ☐ Gym ☐ Cardio ☐ Weights ☐ Stretching ☐ Yoga ☐ Pilates ☐ Golf

My Family History

	Mother	Father	Brother	Sister
Alive? (Y/N)				
Age				
Heart attack				
Diabetes				
Hypertension				
Stroke				
Cancer/type				
Arthritis/type				
Depression				
Emphysema				
Alzheimer				

Daily Function

ARE YOU ABLE TO check box)	No Difficulty	Some Difficulty	Much Difficulty	Cannot Do
Dress yourself; including laces & buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire body?				
Bend down & pick up clothing from floor?				
Tum regular faucets on and off?				
Get in and out of a car?				

What else do you want the Doctor to know:_____

_____

_____

_____

_____

Patient: _____

Patient Signature

PATIENT SURVEY