Appt. Time and Date :

Direction to our office:

We are located at 1106 N. Cedar St. in the Medical Arts building, which is the old Cedar Street School. Parking is in the rear of the building off from Maple St. Across from Preuss Pets and Su Casa Boutique.

From South Lansing:

North on Cedar/Larch towards Dewitt, turn left of Maple 1 block before Grand River, drive is on Right.

From North Lansing:

South on Cedar St. towards Lansing, cross Grand River Ave. and the 1st street on Left is Maple turn left and our driveway is on the left.

From West Lansing:

Saginaw Hwy. to Larch St. turn left and stay in the left lane turn left on Maple.

Alt route 496 E to Cedar St./Larch Exit, turn right off exit stay to the left to Maple St. & turn left, driveway/parking is on the right.

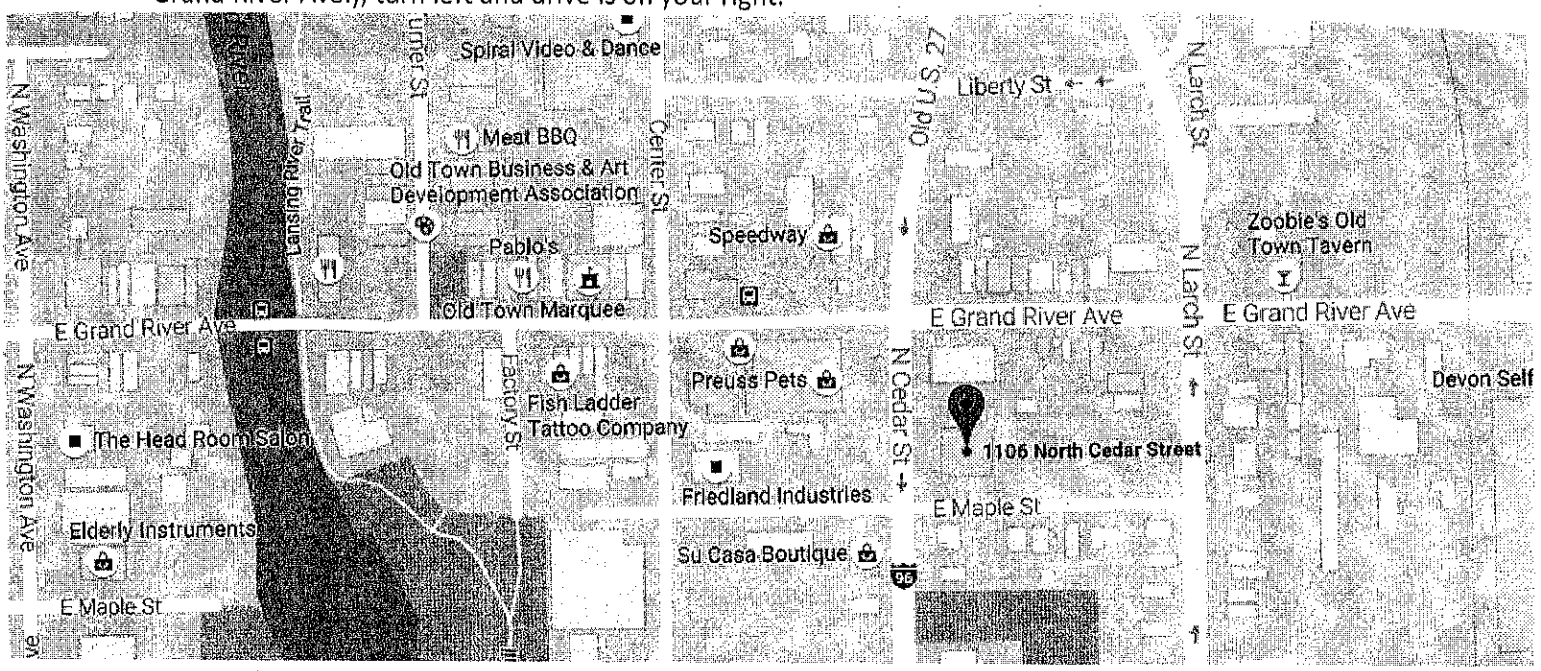
From East:

Lake Lansing Rd. to business 127 and turn left, cross Grand River and Maple is the 1st street on your left.

Grand River Ave from the east, turn left on Cedar St., stay left Maple is the first street turn left, drive is on the left.

Michigan Avenue turn left on Cedar/Larch at the ball park, stay left to Maple, turn left, drive is on the right.

496 West to Cedar St./ Larch exit, turn right on Cedar and stay left until Maple St. (1 block South of Grand River Ave.), turn left and drive is on your right.



Arthritis Care

Dr. Guggenheim
1106 N Cedar Street
Suite 2A
Lansing MI, 48906-5213
Phone (517) 267-0107 Fax (517) 267-9523
Email: acpc11069@gmail.com

Welcome to our office, we appreciate that you have decided to let us participate in your healthcare!

To make your first appointment as effective as possible, we have provided you with the following checklist; please ensure you complete these for your appointment!

- **New Patient Paperwork**
  - Please make sure that ALL of the paperwork included in this packet is completed before your appointment date
  - Bring the completed paperwork with you to your appointment *30-45 minutes BEFORE* your scheduled appointment
- **Medications**
  - If you have an updated medication list from another doctors office or the pharmacy please bring this with you and hand in with the rest of your paperwork
  - You may bring the prescription/supplement bottles into the office for your appointment!
- ***NO SCENTED PRODUCTS***
  - Dr. Guggenheim loses her ability to speak when exposed to most scented products. Please refrain from using any heavy lotions, perfumes, or aftershaves the day of your appointment.
  - If we have to reschedule you due to wearing scented products you will be charged $50 and be rescheduled
- ***SMOKING***
  - If you or anyone you live with smokes, please ensure that you do not come to your appointment smelling of cigarette smoke as Dr. Guggenheim cannot tolerate this either.
  - If you smell of smoke at your appointment you may be asked to change into a gown or be rescheduled
- **Drivers license and Insurance cards**
  - We MUST have your cards for scanning at your appointment
- Feel free to bring a friend or your partner to your appointment. Please leave small children at home. Your appointment may take 1-2 hours
- Wear comfortable clothes that can easily expose your knees and feet
- **If you need to reschedule, please give us AT LEAST 24 HOUR notice. No show appointments will be charged $50 and may not be rescheduled**

Arthritis Care, P.C., CARLA GUGGENHEIM D.O.

1106 N. Cedar St., Ste. 2A Lansing, MI 48906-5213
Phone (517) 267-0107 Fax (517) 267-9523

PATIENT NAME: _____
First Middle Last

Race: White/Caucasian ◯ Black/African American ◯ Asian ◯ Native American ◯
Native Hawaiian ◯ Are you Hispanic ◯

Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯ Partnered ◯

BIRTHDATE: _____ SEX: M / F SS#_____

ADDRESS: _____

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ PHARMACY: _____

EMPLOYER NAME: _____
FT ◯ PT ◯ SELF EMPLOYED ◯ RETIRED ◯ NONE ◯
PRIMARY INSURANCE: _____ (ie Medicare/Private Ins)

Group # _____ Contract # _____

SPOUSE'S NAME: _____ D.O.B.: _____
SPOUSE'S EMPLOYER: _____ INS: _____

GROUP #: _____ CONTRACT #: _____

EMERGENCY CONTACT: _____ Relationship: _____
EMERG. CONTACT NUMBER (Not your own number): _____

***BRING ALL INSURANCE CARDS (Primary, Secondary, Tertiary if applicable) & PHOTO ID

Is your Complaint: Accident Related ◯ Workers Comp ◯ Auto Accident ◯ DATE: _____

PRIMARY PHYSICIAN _____ PHONE: _____

E-Mail Address: _____

GENERAL MEDICAL INFORMATION

Name: _____ **Date:** _____

Age: _____ **Occupation:** _____ **Employer:** _____

Referred By: _____ **Primary Physician:** _____

Please circle the following that apply:

Right-Handed Left Handed Either: Married Single Divorced Widowed

Female or Male **Name of Significant other** _____

FOR WHAT PROBLEM (S) ARE YOU COMING TO SEE US FOR? What is your biggest health concern at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHEN DID SYMPTOMS BEGIN? _____

DID SOMETHING CAUSE THIS? _____

DESCRIBE THE FACTS RELATING TO THE BEGINNING OF THE SYMPTOMS?

_____

_____

_____

_____

_____

_____

_____

In a motor vehicle accident? Yes or No, If yes answer the following: Date of accident:

_____

Were you the driver? Yes or No

In a work related accident? Answer the following:Date of injury: _____

Are you on workman's comp? Yes or No, Are you off work because of this accident? Yes or No?

If yes please provide the date you last worked? _____. Is there a lawsuit pending? Yes or N

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following? (Please Circle Answer)

Allergies	Depression	Myocardial infarction (heart attack)
Anemia	Diabetes Mellitus	Nerve/muscle disease
Anxiety	Emphysema	Osteoporosis
Heart Murmur	GERD	Seizures
Asthma	Glaucoma	Sickle cell anemia
Blood Transfusion~ Year?	Arthritis/Type?	Stroke
Cancer ~ Type?	HIV/AIDS	Fractures ~ Type?
Cataracts	Hyperlipidemia	Thyroid disease ~ Type?
Congestive heart failure	Hypertension	Tuberculosis
Clotting disorder	Kidney disease ~ Type?	Mental illness ~ Type?
COPD	Meningitis	Headaches
Ulcers	Memory loss	Ankylosing Spondyitis
Polymyalgia rheumatica	Psoriasis	Skin disease
Lupus	Pregnancy losses	Gout
Fibromyalgia	Parkinson's disease	Head injury ~ Type & cause?
Pleurisy	Hemorrhoids	Carotid Artery Disease
Varicose veins	Superficial blood clots	Substance abuse

Other, Please list:

SURGICAL HISTORY

Please circle any procedure you have had and be sure to include the year:

Appendix	Tonsils	Brain surgery
Breast surgery	Gall bladder	Cosmetic surgery
C-section	Eye surgery	Fracture surgery
Hernia repair	Hysterectomy	Joint replacement
Prostate surgery	Small intestine surgery	Tubal ligation
Valve replacement	Vasectomy	Deviated septum

Please list any other surgeries you have had that are not listed above

Type Year

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

FAMILY HISTORY

Not Including You: (Please Circle), Please indicate what family member has this diagnosis. (Example: mother, father, brother, sister, grandparents, children/son or daughter, maternal aunt or uncle. Paternal (father's side)/Maternal (mother's side).

Mother's name & living status: _____

Father's name & living status: _____

Arthritis	Birth defects	Fibromyalgia	COPD
Depression	Diabetes	Early birth	Hearing loss
Heart disease	High blood pressure	High cholesterol	Kidney disease
Learning disabilities	Mental illness	Mental retardation	Miscarriages
Stroke	Substance abuse	Vision loss	Asthma
Seizures	Headaches	Parkinson's disease	Dementia
Tremors	Ankylosing spondylitis	Plolymyalgia rheumatic	Gout
Psoriasis	Lupus	Scleroderma	Breast cancer
Colon cancer	Prostate cancer	Tuberculosis	

Other please list: _____

Please list all current Medications and Supplements you are taking

NAME	DOSE (MG)	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Please list all medications that you are unable to tolerate or caused Allergic Reactions!!

MEDICATION NAME	REACTION CAUSED/ SIDE EFFECT

Diet & Lifestyle

- Typical Breakfast:

- Typical Lunch:

- Typical Dinner:

- Snacks:

1. What are your favorite foods to eat?

2. Do you drink water? Yes or No (Please circle your response), If yes, approximately how many oz per day (1 glass = approx. 8 oz)?

3. Do you drink coffee? Yes or No. Soda? Yes or No.
   If yes, how many ounces per week?

4. Do you exercise? Yes or No
   If yes, what type and how often per week?

Personal/ Social History

1. What is your highest level of education?

   _____

2. Where were you born?

   _____

3. What languages do you speak?

   _____

4. Where have you traveled?

   _____

5. How many hours weeks do you usually drive?

   _____

   Do you have any pets in your home? Yes or No, If yes what kind of pets and how many?

   _____

6. What are your hobbies?

   _____

7. Are you a current smoker? Yes, No or Never. Quit date: _____
   Packs per day: ¼ ½ 1 1.5 2 3 or more

8. Do you drink any alcohol? Yes or No

	Number Per Week:
Glasses of Wine:	
Cans/Bottles of Beer:	
Shots of Liquor:	
Other "Drinks":	

9. Sexually Active: Yes or No Partners: Male or Female
   Method of Birth Control: _____

10. Drug Use: Yes or No
    Types: Marijuana, Methamphetamine, Cocaine , IV, Prescription Medications
    Other: _____

11. Domestic Violence/Abuse/Neglect:
    Has anyone ever hit, kicked or used force in any way upon you? Yes or No