

## Treating Disorders of the Joints, Bones and Muscles

At Carilion Clinic, our expert rheumatologists are trained in the diagnosis and treatment of musculoskeletal disease and systemic autoimmune conditions that can cause, swelling, stiffness, tenderness and deformity. Our practice has special interests in diseases and treatments such as:

- Rheumatoid Arthritis
- Systemic Lupus Erythematosus
- Spondyloarthritis: such as Psoriasis & Ankylosing Spondylitis
- Myositis
- Clinical Research and Drug Trials

### Meet Our Team of Providers



Adegbenga Bankole, M.D.  
Division Chief & Program Director



Jeff Croteau, M.D.



Carl Henderson, D.O.



Samara Khalique, M.D.



Jane Nwaonu, M.D.



Gita Verma, M.D.



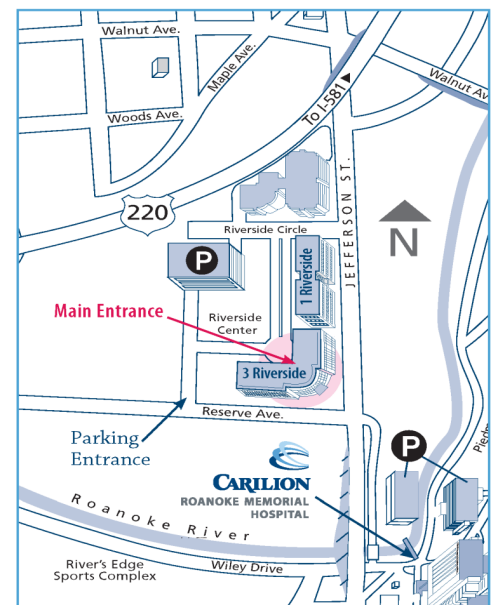
Sandy Sandridge-Moser, D.N.P., F.N.P.-C.

**CARILION CLINIC RHEUMATOLOGY**  
 3 Riverside Circle  
 Roanoke, VA 24016  
 Monday - Friday, 8 a.m. - 5 p.m.  
 540-224-5170 or 877-827-2836

### NEW Appointments:

To help our office prepare for your first appointment, please have your primary care provider obtain and send us your referral, insurance authorization and medical record. We will mail you a medical history sheet to complete and return to us before scheduling your first appointment.

For emergencies after hours, please call 540-981-7000 and have the operator page the on-call physician. Your call will be returned promptly by a physician from the Carilion Clinic Rheumatology provider staff. Work-in appointments are also available for rheumatological problems.



## How Do I Get There?

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Shuttle service is available for your convenience at the Riverside Center garage. In addition, there is a convenient drop-off area located in the circular drive at the front entrance to the building. Parking assistance is also available.

### FROM THE NORTH (BOTETOURT, NORTH ROANOKE, I-81):

- Take I-81 to Exit 143: I-581 South/Route 220 South, toward downtown
- Take Exit 6: Route 24 West/Elm Avenue toward downtown
- Turn right onto Elm Avenue SE toward downtown
- Go to the second traffic light and turn left onto S. Jefferson Street
- Follow S. Jefferson St. to Reserve Avenue and turn right onto Reserve Avenue
- Turn right into Riverside Center and either park in the parking lot on the right or straight to the parking garage

### FROM THE SOUTH (BOONES MILL, SOUTH ROANOKE, FRANKLIN COUNTY, ROUTE 220):

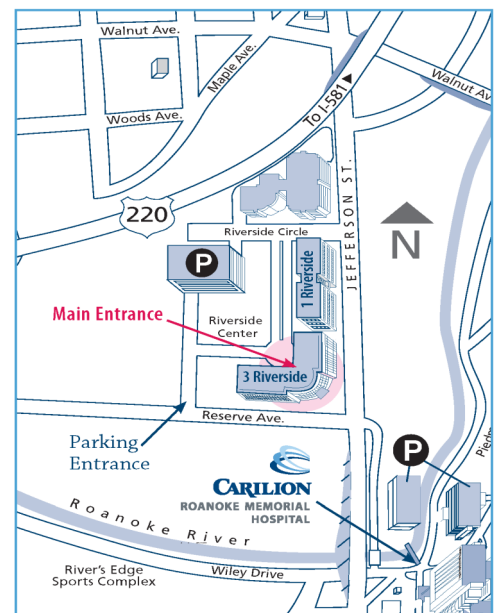
- Take Route 220/I-581 North toward Roanoke
- Take Route 220 Business/Franklin Road ramp toward Salem (Route 419 North)
- Turn right onto Route 220 Business North/Franklin Road toward Roanoke Frontage Road
- Proceed 2 miles
- Turn right onto Reserve Avenue and stay in left lane
- Turn left into Riverside Center and either park in the parking lot on the right or straight to the parking garage

### FROM THE EAST (VINTON, BONSAK, BEDFORD COUNTY, 460 WEST):

- Take Route 460 West toward Roanoke (460 West becomes Orange Avenue)
- Merge onto 581 South/220 South on the right toward downtown Roanoke
- Take Exit 6: Route 24 West/Elm Avenue toward downtown
- Turn right onto Elm Avenue SE toward downtown
- Go to the second traffic light and turn left onto S. Jefferson Street
- Follow S. Jefferson St. to Reserve Avenue and turn right onto Reserve Avenue
- Turn right into Riverside Center and either park in the parking lot on the right or straight to the parking garage

### FROM THE WEST (SALEM):

- Take Electric Road/Route 419 South toward Roanoke
- Electric Road/Route 419 South becomes Route 220 Business North/Franklin Road
- Proceed 2 miles
- Turn right onto Reserve Avenue and stay in left lane
- Turn left into Riverside Center and either park in the parking lot on the right or straight to the parking garage





### Patient History Form

Name: \_\_\_\_\_  
Last First Middle Initial Maiden

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Age: \_\_\_\_ Sex: \_\_\_\_

Address: \_\_\_\_\_  
Street Apt.#

\_\_\_\_\_  
City State Zip

Date of first appointment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of appointment \_\_\_\_\_  
Month Day Year

Birthplace: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Spouse/Significant other: Alive/Age \_\_\_\_ Deceased/Age \_\_\_\_

Education (circle highest level attended) Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School \_\_\_\_\_

Occupation \_\_\_\_\_

Describe briefly your present symptoms:

\_\_\_\_\_  
\_\_\_\_\_

Date symptoms began (approximately) \_\_\_\_\_

Previous treatment for this problem (include physical therapy, surgery and injections only) \_\_\_\_\_

Date of last Mammogram: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_ Date of last bone densitometry test: \_\_\_\_\_

## System Review

As you review the following list, please check any of those problems, which have significantly affected you

### CONSTITUTIONAL

- Recent weight gain amount \_\_\_\_\_
- Recent weight loss amount \_\_\_\_\_
- Weakness
- Fever

### EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eye
- Itching eyes

### EARS—NOSE—MOUTH—THROAT

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Sores in mouth
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

### CARDIOVASCULAR

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

### RESPIRATORY

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough /  Coughing of blood

### GASTROINTESTINAL

- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Jaundice
- Changes in stool
- Blood in stools
- Black stools
- Heartburn

### GENITOURINARY

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy "smokey" urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ ulcers

### FOR WOMEN ONLY

Age when period began: \_\_\_\_\_

Periods regular?  Yes  No

How many days apart? \_\_\_\_\_

Date of last period \_\_\_/\_\_\_/\_\_\_/

Date of last pap \_\_\_/\_\_\_/\_\_\_/

Bleeding after menopause  Yes  No

Number of pregnancies \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

### MUSCULOSKELETAL

Morning stiffness How long? \_\_\_mins \_\_\_hours

- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling

### INTEGUMENTARY (Skin and/or breast)

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/ bumps
- Hair loss
- Color changes of hands or feet in the cold

### NEUROLOGICAL

- Headaches
- Dizziness
- Fainting
- Muscle weakness
- Loss of consciousness
- Sensitivity or pain of hands and /or feet
- Night sweats

### PSYCHIATRIC

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

### HEMATOLOGIC/ LYMPHATIC

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion/ when? \_\_\_\_\_

### ALLERGIC / IMMUNOLOGIC

- Frequent sneezing

**SOCIAL HISTORY**

Do you drink caffeinated beverages? **Yes / No** Cups per/ day \_\_\_\_\_

Do you smoke? **Yes / No** Past-how long ago? \_\_\_\_\_

Do you drink alcohol? **Yes / No** Times per /week? \_\_\_\_\_

Has anyone ever told you to cut down on your drinking? \_\_\_\_\_

Do you use drugs for reasons that are NOT medical? **Yes / No**

If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly? **Yes / No**

Type of exercise: \_\_\_\_\_ Amount per/week \_\_\_\_\_

How many hours of sleep do you get at night? \_\_\_\_\_

Do you wake feeling rested? **Yes/ No**

Previous Surgeries

| Type | Year | Reason |
|------|------|--------|
|------|------|--------|

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Any previous fractures? **Yes / No**

Describe: \_\_\_\_\_

Any other serious injuries? **Yes/ No**

Describe: \_\_\_\_\_

Do you know of any blood relative who has or had: (check and give relationship)

- Rheumatoid Arthritis    Gout    Blood Clots    Lupus

Do you have any difficulty with: Please check responses to each question.

|                              | Usually | Sometimes | Never |
|------------------------------|---------|-----------|-------|
| Walking                      |         |           |       |
| Climbing Stairs              |         |           |       |
| Descending Stairs            |         |           |       |
| Sitting down                 |         |           |       |
| Getting up from chair        |         |           |       |
| Reaching behind your back    |         |           |       |
| Reaching behind your head    |         |           |       |
| Dressing yourself            |         |           |       |
| Bathing                      |         |           |       |
| Eating                       |         |           |       |
| Working                      |         |           |       |
| Engaging in leisure activity |         |           |       |

**PAST MEDICAL HISTORY**

Do you now or have you ever had (check if "YES")

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart problems  | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Leukemia        | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Nervous breakdown   | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Colitis        |
| <input type="checkbox"/> Bad Headaches       | <input type="checkbox"/> Jaundice        | <input type="checkbox"/> Glaucoma       |
| <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Psoriasis      |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis   |

Other significant illness (please list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Natural or alternative therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

|        | LIVING |        | DECEASED |       |
|--------|--------|--------|----------|-------|
|        | Age    | Health | Age      | Cause |
| Father |        |        |          |       |
| Mother |        |        |          |       |

Number of siblings \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

Ages of children: \_\_\_\_\_

Health of children \_\_\_\_\_

**Medications**

Drug allergies: \_\_\_ No \_\_\_ Yes To what? \_\_\_\_\_

Types of reactions: \_\_\_\_\_

**PRESENT MEDICATIONS**

(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

| Name of Drug | Dose (include strength & number of pills per day) | How long have you taken this medication | Please check: Did it help? |      |            |
|--------------|---|---|----------------------------|------|------------|
|              |   |   | A Lot                      | Some | Not At All |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |
|              |   |   |                            |      |            |

**Activities of daily living**

Do you have stairs to climb? \_\_\_ Yes \_\_\_ No If yes, how many? \_\_\_\_\_

How many people in your household? \_\_\_\_\_

Relationship and ages of each \_\_\_\_\_

Who does most of the housework? \_\_\_\_\_ Who does most of the shopping? \_\_\_\_\_

Who does most of the yard work? \_\_\_\_\_

On the scale below, circle a number which best describes your situation; most of the time, I function.....

