INTRODUCTION

The Johns Hopkins Scleroderma Center was established to provide care for patients with scleroderma and to conduct research to work towards new treatment. The Center provides state-of-the-art medical care through the care by scleroderma experts and by the medical faculty at Johns Hopkins University. The Center is also a place for teaching patients and physicians about scleroderma. It is a major Center in the United States that does both basic and clinical scleroderma research.

PHYSICIANS:

Fredrick M. Wigley, M.D.  
*Special Interests:* Scleroderma and Raynaud’s Phenomenon

Laura K. Hummers, M.D.   
*Special Interests:* Scleroderma and Scleromyxedema

Francesco Boin, M.D.  
*Special Interests:* Scleroderma and Fibrosing Skin Disorders

Each patient will be seen by one of the Scleroderma Center physicians. The Center has a number of other specialists in other fields with expertise in the problems that you may experience with scleroderma. Our clinical staff is available for patient problems, support, and education.

The Center is also very active in research. This research includes studies investigating the causes of scleroderma: 1) trials of new medications and treatments for scleroderma; 2) investigations into scleroderma lung disease; and 3) studies of the blood vessel disease of scleroderma and related Raynaud’s phenomenon.
Today's Date __________________

Dear __________________________:

You have been scheduled for an appointment in the Johns Hopkins Scleroderma Clinic:

Date: ___________________________ Time: ___________________________

LOCATION:
Johns Hopkins Asthma & Allergy Center (see enclosed map and directions)
Division of Rheumatology, 1st Floor, Room 1B7
5501 Hopkins Bayview Circle
Baltimore, Maryland 21224-6801

PARKING:
Please park in the Mid-Campus Lot which is located across from the Johns Hopkins Asthma & Allergy Center (see attached map).

REGISTRATION:
Please arrive 30 minutes prior to your appointment to accommodate parking, Johns Hopkins Security, and the pre-registration process.

WHAT TO BRING:
1. List of present medications
2. Medical Records from your doctor, if available (Medical Records Release Form enclosed)
   • Particularly most recent labs, lung function tests, and ECHO of heart
3. Actual X-rays, CT scans, or other studies ordered by your doctor (if any)

EVALUATION – WHAT TO EXPECT:
You will be seen by a Scleroderma specialist, ______________________________, and maybe by a physician-in-training. Please allow approximately three hours for your evaluation because tests might be scheduled.

INSURANCE:
We will bill your insurance company first; you are responsible only for amount not covered by your insurance. Please bring all of the appropriate forms and insurance cards.

FEE: The maximum fee for the initial visit is approximately $576.00. Co-payments are collected at the time of your visit. You may have additional fees for x-rays or laboratory studies. For your convenience, payments can be made with cash, Visa, MasterCard, travelers’ checks, or personal checks. There is a parking fee (maximum $8.00 – cash only) charged by the Johns Hopkins Bayview Medical Institution.

CANCELLATION:
If you need any further assistance, or wish to cancel your appointment, please call (410) 550-7715. If you cannot make your appointment, please call within 48 hours of your scheduled appointment.

We look forward to meeting you and providing the best possible care.
OUTPATIENT REGISTRATION

PATIENT INFORMATION
Last ___________________________ First ___________________________ M.I. _____ Maiden ___________________________
Sex _______ Marital Status _______ Race _______ DOB ___________________________ SS# ______-____-_____
Address ___________________________________________________ Phone # ___________________________
City ___________________________ State _______ Zip _______ Emergency Contact (Name & Phone) ___________________________
Employer ___________________________ Employer Address ___________________________ Phone ___________________________
City ___________________________ State _______ Zip _______ ___________________________

MEDICAL RECORD INFORMATION
Mother’s Maiden Name ___________________________ First Name ___________________________
Father’s Last Name ___________________________ First Name ___________________________

INSURANCE INFORMATION
Name ___________________________ Policy # ___________________________
Address ___________________________ City ___________________________ State/Zip _______
Phone # ___________________________ Grp/Identification # ___________________________ Effective Date ___________________________

POLICY HOLDER INFORMATION
Is Patient the Policy Holder? (circle YES or NO). If NO, Guarantor Information needed.
Full Name ___________________________ Address ___________________________ Phone # ___________________________
SS# ______-____-______ Employer ___________________________ Address ___________________________
Employer Phone # ___________________________

REFERRING PHYSICIAN
Name ___________________________ Address ___________________________ Phone # ___________________________
Fax # ___________________________ Specialty ___________________________

PRIMARY CARE PHYSICIAN
Name ___________________________ Address ___________________________ Phone # _______ Fax # _______

AUTHORIZATION
In consideration of the treatment of the above patient, I/we agree to pay the applicable charges and professional fees accrued and to pay the balance in full. I/we assign insurance benefits and will submit necessary claim forms to cover the amount due. I/we understand that I/we have the responsibility for any unpaid amount.

Patient/Policy Holder Signature ___________________________ Date ___________________________
MEDICAL RELEASE REQUEST

Date: ______________________

To: __________________________________________

_______________________________________________

_______________________________________________

Please release copies of all medical records, x-rays, CT’s, and other pertinent information to:

☐ Fredrick M. Wigley, M.D.
☐ Laura K. Hummers, M.D.
☐ Francesco Boin, M.D.

Johns Hopkins University
Asthma & Allergy Center
Rheumatology Department, 1st Floor
5501 Hopkins Bayview Circle
Baltimore, MD 21224-6801

If you have any questions regarding this request for information, please do not hesitate to call (410) 550-7715.

Sincerely,

________________________________________
Patient Signature

________________________________________
Print Name

________________________________________
Address

________________________________________
City, State, Zip

________________________________________
Social Security Number

________________________________________
Date of Birth

________________________________________
Phone Number
WELCOME to the Scleroderma Center! Please fill out the following form to help us learn what brings you to our practice and how we can best help you.

Date of visit: __________________________

Your Name: ____________________________

Address: ______________________________

City State Zip Code

Telephone No.: (Home) ____________ (Work) ____________ (Cell) ____________

Date of Birth: ____________ ____________ ____________

Month Day Year

Gender: □ Male □ Female

Is your ethnicity Spanish/Hispanic/Latino?

□ No, not Spanish/Hispanic/Latino □ Yes, Spanish/Hispanic/Latino

Race (Select all that apply):

□ White □ Black or African American □ Indian Sub-Continent

□ Asian □ Native Hawaiian or Other Pacific Islander □ Mid-East/Arabian

□ American Indian/Alaska Native □ Other/Unknown

Marital Status:

□ Single, never married □ Married □ Domestic Partnership □ Divorced

□ Widowed □ Separated

Education (Check highest level completed):

□ Grade School (up to grade 8)

□ High School (received diploma/completed through grade 12)

□ Tech/Trade School (completed a tech/trade school program)

□ College (received college degree)

□ Post-grad (completed post-graduate work)
Employment Status:

☐ Currently employed
☐ Currently unemployed
☐ On disability
☐ Homemaker
☐ Retired

Insurance (Please check one):

☐ None    ☐ Medical Assistance    ☐ Private    ☐ Self-pay    ☐ Medicare

Why have you come to the Johns Hopkins Scleroderma Center?

How long have you had this problem?

Please provide the name, address, phone number of the doctor who referred you and the name(s), addresses, and phone numbers of the doctors who should receive copies of your clinic notes, labs and test results. Clinic Notes and results will be sent to Primary Care Physician and/or Referring Physician ONLY. If the patient requests Clinic Notes and results be sent to any additional physician, there will be a $5.00 charge for each packet sent out.

PRIMARY CARE PHYSICIAN: ________________________________
STREET ADDRESS: ________________________________
CITY, STATE & ZIP CODE: ________________________________
TELEPHONE #: ____________________________ FAX #: ____________________________

DOCTOR'S NAME: ________________________________
STREET ADDRESS: ________________________________
CITY, STATE & ZIP CODE: ________________________________
TELEPHONE #: ____________________________ FAX #: ____________________________

DOCTOR'S NAME: ________________________________
STREET ADDRESS: ________________________________
CITY, STATE & ZIP CODE: ________________________________
TELEPHONE #: ____________________________ FAX #: ____________________________

DOCTOR'S NAME: ________________________________
STREET ADDRESS: ________________________________
CITY, STATE & ZIP CODE: ________________________________
TELEPHONE #: ____________________________ FAX #: ____________________________

DOCTOR'S NAME: ________________________________
STREET ADDRESS: ________________________________
CITY, STATE & ZIP CODE: ________________________________
TELEPHONE #: ____________________________ FAX #: ____________________________
List your current medications (list everything including vitamins, aspirin, birth control pills, etc.)

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>AMOUNT PER DAY</th>
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<tbody>
<tr>
<td>1.</td>
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<td>10.</td>
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</table>

Are you allergic to a medicine? (If yes, name it: __________________)

Do you drink alcohol? ____________________

Do you currently smoke? __________

Are you a former smoker? __________

If YES to either question above, please answer:

a. Age first started smoking: __________
b. Age stopped smoking: __________
c. How many cigarettes do you currently smoke: __________
d. How many cigarettes did you smoke in the past: __________

Do you live with a smoker? __________

Do you work outside the home? __________

Do other people in your family have arthritis? __________

Have you had any major operations? (If yes, name them:) __________________

_____________________________
_____________________________
Have you had any major illnesses (such as TB, hepatitis)?
(If yes, name them: _____________________________)

1. GENERAL HEALTH
   a) Are you having fevers (temperature over 100 degrees)?
   b) Do you have night sweats?
   c) Have you lost more than 5 pounds in the last 3 months?
   d) Do you have problems sleeping?

2. SKIN
   a) Have you had any serious skin rashes?
   b) Do you get rashes from the sun?
   c) Have you had bumps or lumps in your skin?
   d) Have you had psoriasis?
   e) Is your hair falling out?

3. EYES
   a) Have you lost your vision at any time?
   b) Have you had a painful eye (iritis, uveitis)?
   c) Have you had a red eye (conjunctivitis)?
   d) Are your eyes very dry or gritty?

4. EARS
   a) Have you had a swollen or painful outer ear?
   b) Have you had frequent ear infections (otitis)?

5. NOSE
   a) Have you had discharge or bleeding from the nose frequently?

6. MOUTH
   a) Do you have frequent canker sores or mouth ulcers?
   b) Do you have difficulty swallowing a cracker without water?
   c) Have you had a yeast (thrush, candida) infection of the throat?

7. ENDOCRINE
   a) Do you have swollen glands?
   b) Do you have diabetes?
   c) Do you have a thyroid problem?
8. **CHEST**

   a) Have you had pleurisy (a sharp pain when breathing)?
   b) Have you had pneumonia?
   c) Have you had fluid (water, effusion) in your lungs?
   d) Are you short of breath easily?

9. **CARDIAC**

   a) Have you had inflammation of the heart lining (Pericarditis)?
   b) Have you had a heart attack?

10. **GASTROINTESTINAL**

    a) Have you had difficulty swallowing or regurgitating?
    b) Have you ever had stomach ulcers?
    c) Have you had severe prolonged diarrhea?
    d) Have you had blood in your stools frequently?
    e) Do you have “irritable bowel” with diarrhea and constipation?

11. **RENAL**

    a) Have you had kidney failure?
    b) Have you had blood in your urine?
    c) Have you had a kidney stone?

12. **GYN/GU**

    a) (If a woman): Have you had any miscarriages?
    b) (If a man): Have you had urethritis (painful urination)?
                   Have you had a problem with impotence?

13. **EXTREMITIES**

    a) Have you had any swelling (edema) of your feet or ankles?
    b) Have you ever had blood clots (phlebitis)?
    c) Do your fingers or toes turn color in the cold?

14. **NEUROLOGIC**

    a) Have you lost feeling anywhere on your body?
    b) Do you have numbness or tingling in your hands?
    c) Have you had a stroke (shock, paralysis)?
    d) Do you have severe headaches?
    e) Have you developed weakness anywhere in your body?
Your Family History
What is a Family Medical History?

What is a family medical history?

A family medical history is a record of illnesses among family members. As you can see, it is very much like a family tree. It depicts the relationship between each member of your family.

Why is a family medical history important?

By compiling a family medical history, it can help you and your doctors better understand your situation. It can help your doctors spot patterns of specific conditions and diseases among family members. Your family’s medical history can be used for a number of things:

- Diagnosis of a medical condition
- Determining whether you are at high risk for developing certain diseases
- Determining if you may benefit from preventive measures to lower your risk of a specific disease
How to Complete the Family Medical History

The family medical history can be easily completed. From what you KNOW about your family, list the medical history under the corresponding family member’s title. For example, if you would like to note that “Aunt Jane” had Rheumatoid Arthritis you would complete the form this way:

Aunt/Uncle

RA

You would circle “aunt” and list her condition on the lines provided.

There are specific diseases and conditions that we are primarily interested in. If you KNOW that someone in your family history has been diagnosed with one of the conditions listed on the attached sheet, please list it.
# Autoimmune Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Disorder</th>
<th>Disorder</th>
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</thead>
<tbody>
<tr>
<td>Addison’s Disease</td>
<td>Hashimoto’s Thyroiditis</td>
<td>Psoriatic Arthritis and Psoriasis</td>
</tr>
<tr>
<td>Alopecia Areata</td>
<td>Henoch-Schönlein Purpura</td>
<td>Raynaud’s Phenomenon</td>
</tr>
<tr>
<td>Antiphospholipid Syndrome</td>
<td>Idiopathic Thrombocytopenic Purpura (ITP)</td>
<td>Reactive Arthritis (Reiter’s Syndrome)</td>
</tr>
<tr>
<td>Ankylosing Spondylitis</td>
<td>IgA Nephropathy</td>
<td>Relapsing Polychondritis</td>
</tr>
<tr>
<td>Aplastic Anemia</td>
<td>Inflammatory Bowel Disease (Crohn’s or Ulcerative Colitis)</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Autoimmune Hemolytic Anemia</td>
<td>Kawasaki’s Disease</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>Autoimmune Hepatitis</td>
<td>Lupus</td>
<td>Scleroderma</td>
</tr>
<tr>
<td>Behçet’s</td>
<td>Multiple Sclerosis</td>
<td>Sjögren’s Syndrome</td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>Myasthenia Gravis</td>
<td>Still’s Disease</td>
</tr>
<tr>
<td>Churg-Strauss Syndrome</td>
<td>Pemphigus and Bullous Pemphigoid</td>
<td>Takayasu’s Arteritis</td>
</tr>
<tr>
<td>Cryoglobulinemia</td>
<td>Pernicious Anemia</td>
<td>Type 1 Diabetes Mellitus</td>
</tr>
<tr>
<td>Giant Cell Arteritis</td>
<td>Polyarteritis Nodosa</td>
<td>Uveitis</td>
</tr>
<tr>
<td>Goodpasture’s Syndrome</td>
<td>Polymyalgia Rheumatica</td>
<td>Vasculitis</td>
</tr>
<tr>
<td>Grave’s Disease</td>
<td>Polymyositis/Dermatomyositis</td>
<td>Vitiligo</td>
</tr>
<tr>
<td>Guillain-Barré Syndrome</td>
<td>Primary Biliary Cirrhosis</td>
<td>Wegener’s Granulomatosis</td>
</tr>
</tbody>
</table>
Travel Information

Direction Line Available
One phone call to 410-550-5748 provides patients or visitors with directions from the major interstates, and landmarks throughout the city.

A map of the Bayview campus is attached.

Directions:
From points South (including BWI Airport):
Take I-295 north to the Harbor Tunnel Thruway (I-895). After exiting the tunnel, take exit 12, Lombard Street. At the first stop light, proceed straight onto Bayview Boulevard.
or
Take I-95 through the Fort McHenry Tunnel to exit 59 (Eastern Avenue). Turn left onto Eastern Avenue and proceed approximately one mile to Bayview Boulevard on the right.

From points North and East:
Take I-95 south to exit 59 (Eastern Avenue). Turn right onto Eastern Avenue (west) and proceed approximately one mile to Bayview Boulevard on the right.
or
Take I-895 south to exit 12, Lombard Street. At the first stop light, turn right onto Bayview Boulevard.
<table>
<thead>
<tr>
<th>Hotel Name</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admiral Fell Inn</td>
<td>888 South Broadway</td>
<td>410-522-7377, 410-522-0707 (fax)</td>
</tr>
<tr>
<td>Baltimore Marriott Inner Harbor</td>
<td>110 South Eutaw Street</td>
<td>410-962-0202, 1-800-228-9290, 410-625-7892 (fax)</td>
</tr>
<tr>
<td>Biltmore Suites</td>
<td>205 W. Madison St.</td>
<td>410-728-6550 or 1-800-868-5064, 410-728-5829 (fax)</td>
</tr>
<tr>
<td>Brookshire Suites</td>
<td>120 E. Lombard Street</td>
<td>410-625-1300, 1-866-583-4162</td>
</tr>
<tr>
<td>Clarion Hotel Peabody Court</td>
<td>612 Cathedral Street</td>
<td>410-727-7101, 1-800-292-5500, 410-789-3312 (fax)</td>
</tr>
<tr>
<td>Days Inn Baltimore Inner Harbor</td>
<td>100 Hopkins Place</td>
<td>410-576-1000, 1-800-329-7466, 410-576-9437 (fax)</td>
</tr>
<tr>
<td>Harbor Court Hotel</td>
<td>550 Light St.</td>
<td>410-234-0550</td>
</tr>
<tr>
<td>Holiday Inn Inner Harbor</td>
<td>301 West Lombard Street</td>
<td>410-685-3500, 1-800-HOLIDAY, 410-727-6169 (fax)</td>
</tr>
<tr>
<td>Hyatt Regency Baltimore</td>
<td>300 Light Street</td>
<td>410-528-1234, 1-800-233-1234, 410-685-3362 (fax)</td>
</tr>
<tr>
<td>Inn at Henderson's Wharf</td>
<td>1000 Fell St.</td>
<td>410-522-7777, 1-800-522-2088, 410-522-7087 (fax)</td>
</tr>
<tr>
<td>Lancaster House (short-term rental property)</td>
<td>1611 Lancaster Street</td>
<td>443-996-4179</td>
</tr>
<tr>
<td>Pier 5 Hotel*</td>
<td>(next to National Aquarium)</td>
<td>711 Eastern Avenue</td>
</tr>
<tr>
<td>Radisson Plaza Lord Baltimore Hotel</td>
<td>20-30 W Baltimore St.</td>
<td>410-539-2000, 877.207.9047</td>
</tr>
<tr>
<td>Renaissance Harborplace Hotel</td>
<td>202 E. Pratt St.</td>
<td>410-547-1200, 410-539-5780 (fax)</td>
</tr>
<tr>
<td>Sheraton Inner Harbor Hotel</td>
<td>300 S. Charles St.</td>
<td>410-962-8300</td>
</tr>
<tr>
<td>Tremont Suite Hotels</td>
<td>222 Street Paul Place</td>
<td>410-727-2222, 410-685-4215 (fax)</td>
</tr>
<tr>
<td>Wyndham Balto. Inner Harbor Hotel</td>
<td>101 W. Fayette St.</td>
<td>410-752-1100, 410-752-0832 (fax)</td>
</tr>
</tbody>
</table>

* Take hotel shuttle to Main Hospital, then take Hopkins’ shuttle van to Bayview
** Free taxi vouchers (requests only)