

**Johns Hopkins Scleroderma Center**

5501 Hopkins Bayview Circle, Room 1B7  
Baltimore, MD 21224-6801  
410-550-7715/FAX 410-550-1363

## 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, 1<sup>st</sup> 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 \_\_\_\_\_

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## 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, 1<sup>st</sup> 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



**Johns Hopkins Scleroderma Center  
NEW PATIENT INFORMATION**

**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)

**Scleroderma Center  
NEW PATIENT INFORMATION  
PAGE 2**

**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 #:** \_\_\_\_\_

Scleroderma Center  
 NEW PATIENT INFORMATION  
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List your current medications (list everything including vitamins, aspirin, birth control pills, etc.)

	<u>MEDICINE</u>	<u>AMOUNT PER DAY</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

NO    YES

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_)

\_\_\_\_\_

NO      YES

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?

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



	<u>NO</u>	<u>YES</u>
<b>8. <u>CHEST</u></b>		
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?	_____	_____
<b>9. <u>CARDIAC</u></b>		
a) Have you had inflammation of the heart lining (Pericarditis)?	_____	_____
b) Have you had a heart attack?	_____	_____
<b>10. <u>GASTROINTESTINAL</u></b>		
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?	_____	_____
<b>11. <u>RENAL</u></b>		
a) Have you had kidney failure?	_____	_____
b) Have you had blood in your urine?	_____	_____
c) Have you had a kidney stone?	_____	_____
<b>12. <u>GYN/GU</u></b>		
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?	_____	_____
<b>13. <u>EXTREMITIES</u></b>		
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?	_____	_____
<b>14. <u>NEUROLOGIC</u></b>		
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.

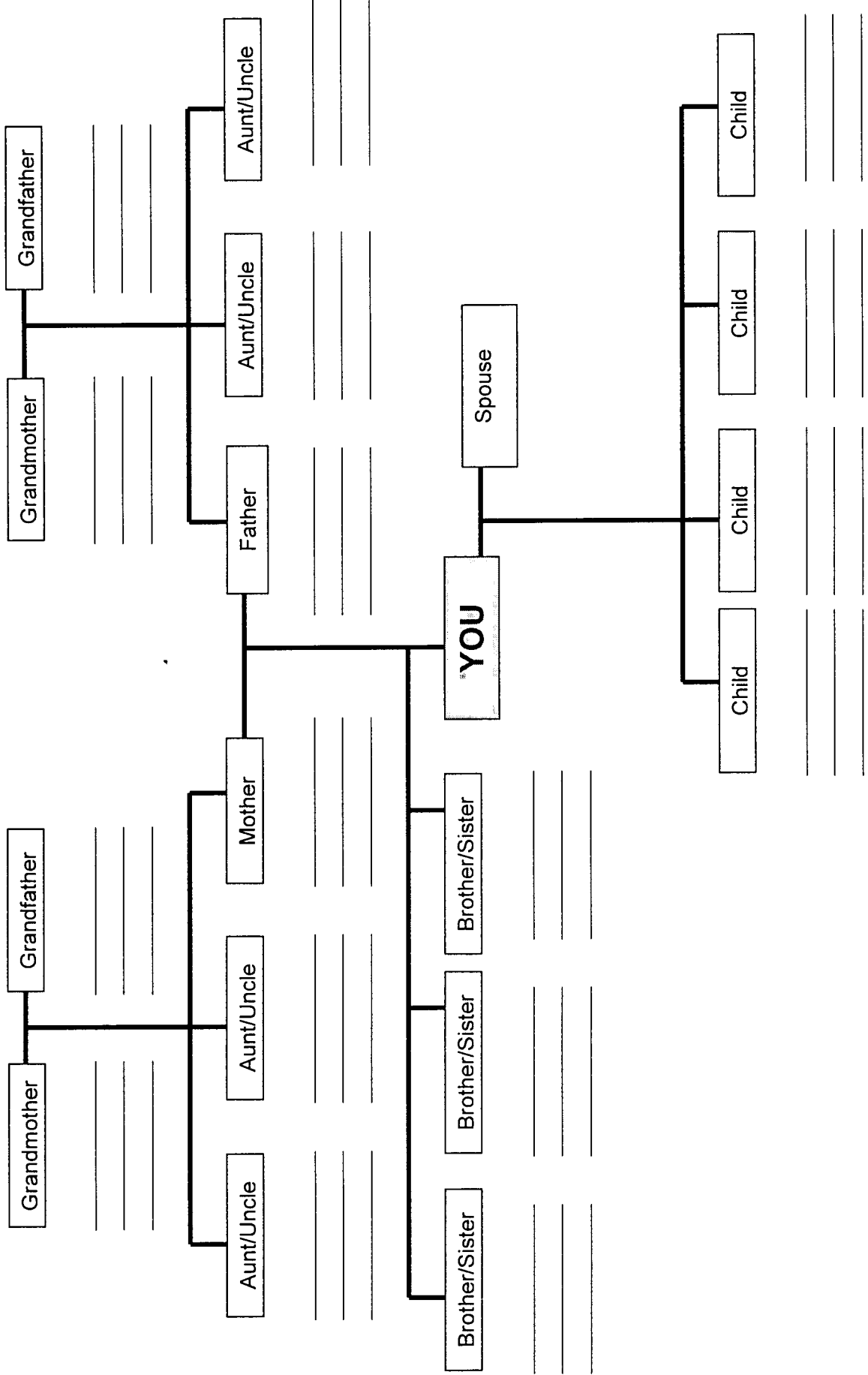
There are specific diseases and conditions that we are primarily interested in. If you *KNOW* that someone in your family history has been *diagnosed* with one of the conditions listed on the attached sheet, please list it.

Family Medical History

Please check here if you are one of twins

Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Autoimmune Disorders

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



## **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.

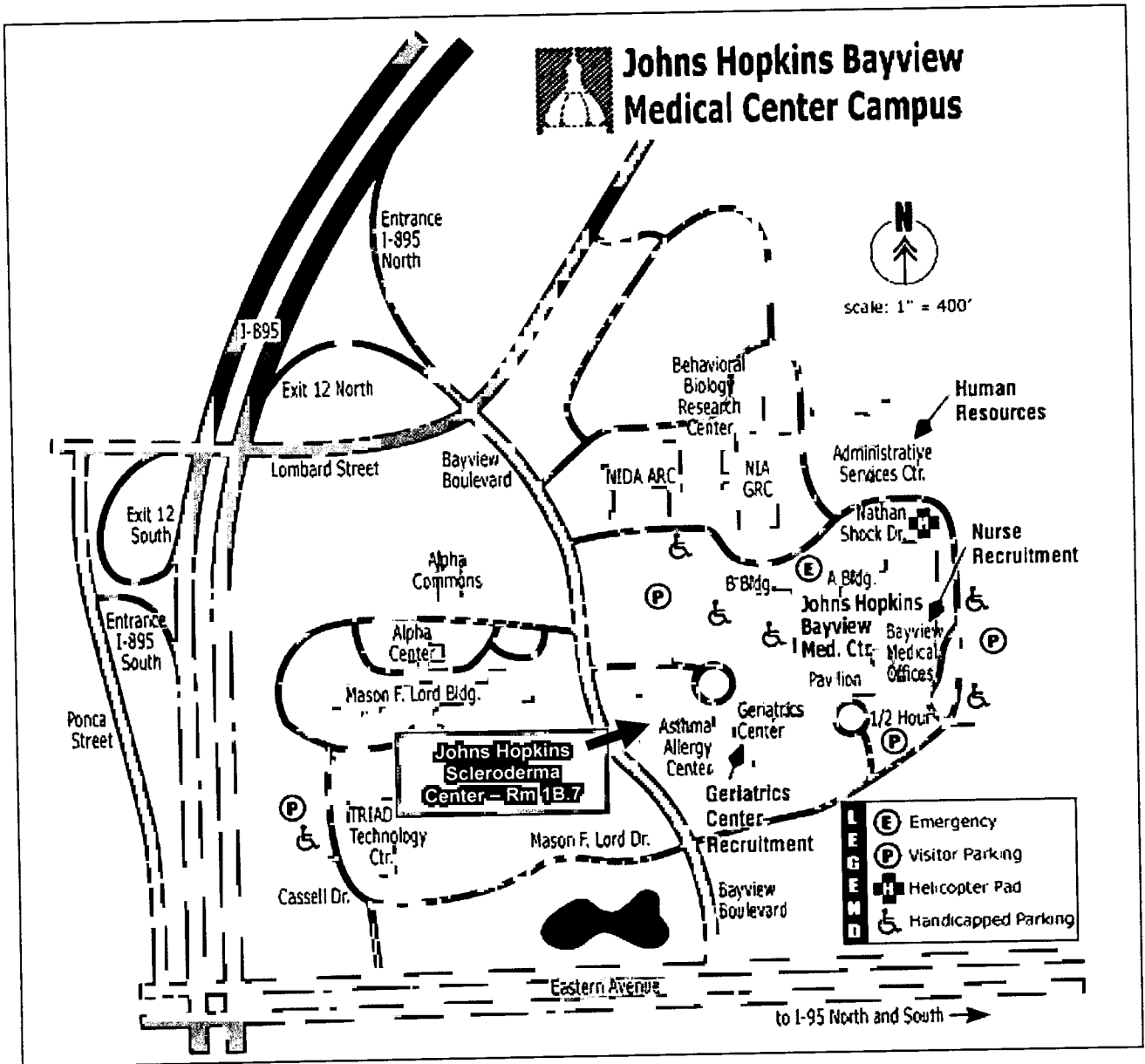
#### **From points North and East: ,**

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.

# JOHNS HOPKINS BAYVIEW MAP





**Johns Hopkins Travel Department 800-225-2201**  
**Hotels Near Baltimore's Inner Harbor**

**Admiral Fell Inn\***

888 South Broadway  
Baltimore, MD 21231  
410-522-7377  
410-522-0707 (fax)

**Baltimore Marriott Inner Harbor**

110 South Eutaw Street  
Baltimore, MD 21201  
410-962-0202, 1-800-228-9290  
410-625-7892 (fax)

**Biltmore Suites**

205 W. Madison St.  
Baltimore, MD 21201  
410-728-6550 or 1-800-868-5064  
410-728-5829 (fax)

**Brookshire Suites\***

120 E. Lombard Street  
Baltimore, MD 21202  
410-625-1300, 1-866-583-4162

**Clarion Hotel Peabody Court**

612 Cathedral Street  
Baltimore, MD 21201  
410-727-7101, 1-800-292-5500  
410-789-3312 (fax)

**Days Inn Baltimore Inner Harbor**

100 Hopkins Place  
Baltimore, MD 21201  
410-576-1000, 1-800-329-7466  
410-576-9437 (fax)

**Harbor Court Hotel**

550 Light St.  
Baltimore, MD 21202  
410-234-0550

**Holiday Inn Inner Harbor**

301 West Lombard Street  
Baltimore, MD 21201  
410-685-3500, 1-800-HOLIDAY  
410-727-6169 (fax)

**Hyatt Regency Baltimore**

300 Light Street  
Baltimore, MD 21202  
410-528-1234, 1-800-233-1234  
410-685-3362 (fax)

**Inn at Henderson's Wharf\*\***

1000 Fell St.  
Baltimore, MD 21231  
410-522-7777, 1-800-522-2088  
410-522-7087 (fax)

**Lancaster House (short-term rental property)**

1611 Lancaster Street  
Baltimore, MD 21231  
443-996-4179

**Mt. Vernon Hotel**

24 W. Franklin Street  
Baltimore, MD 21201  
410-727-2000, 1-800-245-5256  
410-576-9300 (fax)

**Pier 5 Hotel\***

**(next to National Aquarium)**  
711 Eastern Avenue  
Baltimore, Maryland 21202  
410-539-2000, 877.207.9047

**Radisson Plaza Lord Baltimore Hotel\***

20-30 W Baltimore St.  
Baltimore, MD 21201  
410-539-8400

**Renaissance Harborplace Hotel**

202 E. Pratt St.  
Baltimore, MD 21202  
410-547-1200  
410-539-5780 (fax)

**Sheraton Inner Harbor Hotel**

300 S. Charles St.  
Baltimore, MD 21201  
410-962-8300

**Tremont Suite Hotels**

222 Street Paul Place  
Baltimore, MD 21202  
410-727-2222  
410-685-4215 (fax)

**Wyndham Balto. Inner Harbor Hotel**

101 W. Fayette St.  
Baltimore, MD 21201  
410-752-1100  
410-752-0832 (fax)

\* Take hotel shuttle to Main Hospital, then take Hopkins' shuttle van to Bayview

\*\* Free taxi vouchers (requests only)