Rheumatology

MRN: ☐☐☐☐☐☐☐☐

LAST Name ☐☐☐☐☐☐☐☐☐☐☐☐ FIRST Name ☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐

Date of Visit ☐☐ / ☐☐ / 2 0 ☐☐
M M D D Y Y Y Y

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
M M D D Y Y Y Y

If we may contact you by email, please provide address: ☐

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1. How many years of school have you completed?
Please X the box to the left of the number of years of school.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17+ ____________

|- - - - - - - - - -**Grade School** - - - - - - - - - -| |- - - - **High School** - - - -| |- - - - - - -**College**- - - - - - -| **Post college or Other**

Please tell us your ethnic background: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ American Indian/Alaska Native ☐ Puerto Rican ☐ Other

Please tell us your marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Please tell us your occupational status:
☐ Full-time ☐ Part-time ☐ Homemaker ☐ Retired ☐ Student ☐ Disabled ☐ Other (describe ________________)

What is your current occupation? (If you are not working now, what was your past occupation? ______________________________

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2. Please indicate your smoking history:

Have you smoked more than 100 cigarettes in your entire life? ☐ no ☐ yes **If YES, do you currently smoke?** ☐ no ☐ yes	**IF YOU HAVE SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFE:** **How many years total have you smoked?** ☐☐ **years** **On average, how many packs of cigarettes did/do you smoke per day (20 cigarettes/pack, write '1' if less than one pack per day)?** ☐☐ **packs**

3. Please mark either NO or YES to indicate whether or not you have any of the conditions below.
If you answer YES, please write your AGE when the problem began.

	No	Yes	Age		No	Yes	Age		No	Yes	Age
High blood pressure	☐	☐		Gyneco. problems (women)	☐	☐		Stomach ulcer	☐	☐	
Heart Attack	☐	☐		Prostate problems (men)	☐	☐		Cancer	☐	☐	
Other heart disease	☐	☐		Osteoporosis (thin bones)	☐	☐		Stroke	☐	☐	
Lung Disease	☐	☐		Broken bones after age 50	☐	☐		Depression	☐	☐	
Anemia (low blood)	☐	☐		Thyroid Disease	☐	☐		Diabetes	☐	☐	
Kidney Problems	☐	☐		Osteoarthritis	☐	☐		Liver disease	☐	☐	
Seizures	☐	☐		TB Exposure	☐	☐		Blood clot	☐	☐	

4. Please list any medications which you cannot take because of allergies and list the allergic reaction associated with each medicine.

	Medicine	Reaction
1.	________________	________________
2.	________________	________________
3.	________________	________________

5. Please list below all OPERATIONS you have had. Place a mark here if NONE: ☐

	Operation	Year	Surgeon	Hospital, City, State
1.				
2.				
3.				
4.				
5.				

6. Please list below all major illnesses or admissions to a hospital (other than operations). Place a mark here if NONE: ☐

	Reason for Admission	Year	Hospital, City, State
1.			
2.			
3.			

7. Do you have a blood relative with:

			If YES, Relation(s)
Rheumatoid Arthritis:	☐ no	☐ yes	
Lupus:	☐ no	☐ yes	

8. Do any other illnesses run in your family? ☐ no ☐ yes

If YES, illness and family member(s)

____

____

9. Place an 'X' in the ONE best answer for your abilities at this time:

AT THIS MOMENT, are you able to:	without **ANY** difficulty	with **SOME** difficulty	with **MUCH** difficulty	**UNABLE** to do
Stand up from a straight chair?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Walk outdoors on flat ground?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Get on/off toilet?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Open car doors?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Do outside work (such as yard work)?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Wait in a line for 15 minutes?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Lift heavy objects?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Move heavy objects?	☐ **0**	☐ **1**	☐ **2**	☐ **3**
Go up two or more flights of stairs?	☐ **0**	☐ **1**	☐ **2**	☐ **3**

HAQ2 (0-3) ☐

10. How much pain have you had because of your condition OVER THE PAST WEEK?
Place an X in the box that best describes the severity of your pain.

NO PAIN ☐ 0.0 ☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0 ☐ 7.5 ☐ 8.0 ☐ 8.5 ☐ 9.0 ☐ 9.5 ☐ 10 **SEVERE PAIN**

11. How much of a problem has fatigue or tiredness been for you IN THE PAST WEEK?
Place an X in the box below that best describes the severity of your fatigue.

FATIGUE IS NO PROBLEM ☐ 0.0 ☐ 0.5 ☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0 ☐ 7.5 ☐ 8.0 ☐ 8.5 ☐ 9.0 ☐ 9.5 ☐ 10 **FATIGUE IS A MAJOR PROBLEM**

12. Considering ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, rate how you are doing:
Place an X in the box below that best describes how you are doing.

VERY WELL ☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100 **VERY POOR**

13. If you are stiff in the morning, about how long does the stiffness last?
☐ No stiffness ☐ 30 min or less ☐ >30 min - 1 hr ☐ >1-2 hrs ☐ >2-4 hrs ☐ >4-8 hrs ☐ More than 8 hrs

14. In the last MONTH have you experienced any of the following?

GENERAL	**HEAD & NECK**	**HEART & BREATHING**	**SKIN**
☐ fever	☐ dry mouth	☐ shortness of breath	☐ easy bruising
☐ chills	☐ dry eyes	☐ coughing	☐ rashes
☐ weight loss (>10lbs)	☐ mouth sores	☐ wheezing	☐ sun sensitivity
☐ weight gain (>10lbs)	☐ ringing ears	☐ chest pain	☐ swollen glands
☐ cigarette smoking	☐ red eye	☐ color change in toes/fingers	☐ hair loss
☐ ***None of the above***	☐ ***None of the above***	☐ swelling in one leg	☐ tightening skin
		☐ ***None of the above***	☐ ***None of the above***
GASTROINTESTINAL	**URINARY/GYN**	**NEUROLOGY**	**OTHER**
☐ trouble swallowing	☐ gyneco/prostate problems	☐ numbness	☐ depression
☐ diarrhea	☐ problems with urination	☐ tingling	☐ anxiety
☐ constipation	☐ bloody urine	☐ weakness	☐ problems sleeping
☐ heartburn	☐ cloudy urine	☐ headaches	☐ ***None of the above***
☐ dark/bloody stools	☐ ***None of the above***	☐ ***None of the above***	
☐ nausea			
☐ vomiting			
☐ ***None of the above***			

Continue questions on back...

15. For women: do you want to get pregnant in the next year? ☐ No ☐ Yes ☐ N/A

16. If you have psoriasis select the sites where it is currently active:

☐ Face	☐ Scalp	☐ Ear(s)	☐ Neck
☐ Genitals	☐ Gluteal cleft (buttock crack)	☐ Other parts of buttock(s)	☐ Trunk (including chest, back and belly)
☐ Arms or legs	☐ Palms or soles	☐ Other parts of hands or feet	☐ **None/Not active**

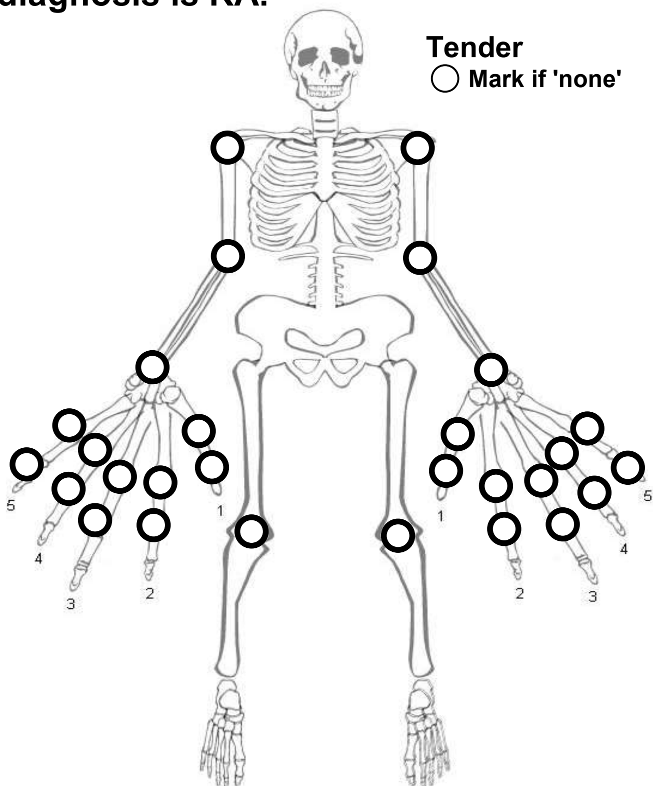
THIS SECTION FOR PHYSICIAN USE

Physician psoriasis assessment: BSA (0-100%; Area of patient's handprint ~1%) ______ **%**

If diagnosis is RA:

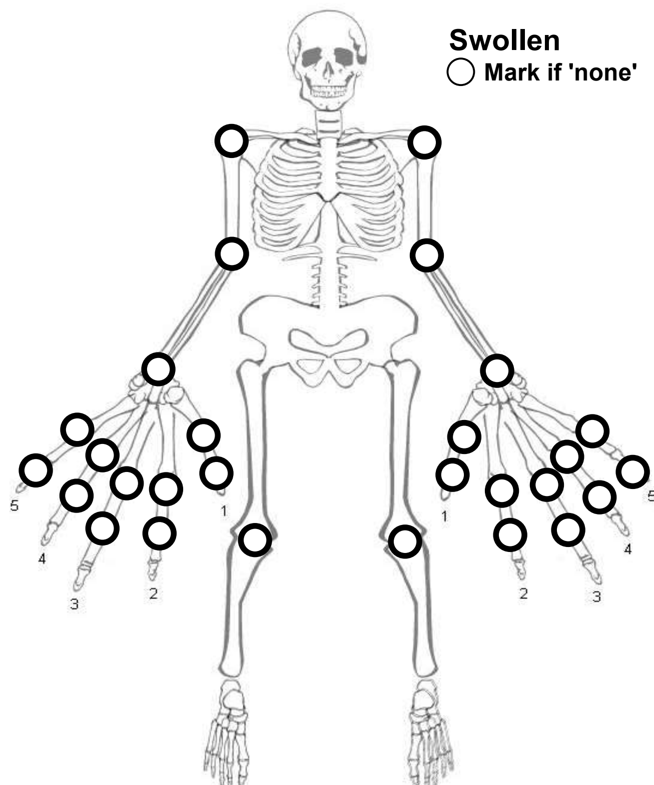
Tender

◯ **Mark if 'none'**



Swollen

◯ **Mark if 'none'**



Physicians assessment of global disease activity:

0	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

NONE **MILD** **MODERATE** **SEVERE**

Notes: ____________________