American College of Rheumatology

Patient History Update

What has happened since you were last here?

Name _____ Date _____

Since your last visit, have you?	Yes	No	**If yes, please specify**
Had any illnesses?	☐	☐	_____
Seen any health care providers?	☐	☐	_____
Had any x-ray, lab or other procedures?	☐	☐	_____
Had any change in your family medical history?	☐	☐	_____
Had any change in your social life?	☐	☐	_____
Had any new allergies or reactions to medications?	☐	☐	_____
Started, changed or stopped any medications?	☐	☐	_____

New diseases or illnesses developed by Relatives (parents, children, aunts, uncles brothers, sisters).	Changes in your social situation: Work; relationships, residence, smoking, alcohol consumption	New Allergies or reactions to medications

Please list all medications you are currently taking.

Name of Medication	New, Change or Stop (for dose change, indicate current dosage)	Name of Prescribing doctor. If you made the change, put self

How Do You Feel Today as Compared to Your Last Visit Here? Please rate the following items using this scale:

0=Problem not present today 1=Much better 2=Better 3=Same 4=Worse 5=Much Worse N=New Problem

Pain:	Red Eyes:	Sore Throat:	Heart Palpitations:	Indigestion/ Reflux:	Numbness/Tingling	Fatigue:
Swelling:	Ringing in Ears:	Trouble Swallowing:	Cough:	Difficulty Urinating:	Difficulty Sleeping:	Concentration/Memory
Headache:	Nasal Congestion:	Swollen Glands:	Shortness of Breath:	Rash	Depression:	Weight Change:
Dry Eyes:	Oral Ulcers:	Chest Pain:	Upset Stomach:	Bruising:	Stress level:	Overall Assessment:

How long is your morning stiffness (minutes) _____ What is your worst joint? _____

Physician Signature _____

Rheumatology Associates, S.C.

Date_____/_____/_____ Time:_____

Name_____
LAST FIRST MIDDLE

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE.**

1	2	3	4	5	6	7	8	9	10
No Pain									Pain as bad as you can image

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

A. Mood

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

B. Energy

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

C. Concentration

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

E. Memory

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

F. Walking ability

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

G. Normal work (includes both work outside the home and house)

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

H. Relations with other people

1	2	3	4	5	6	7	8	9	10
Des not interfere									Completely interferes

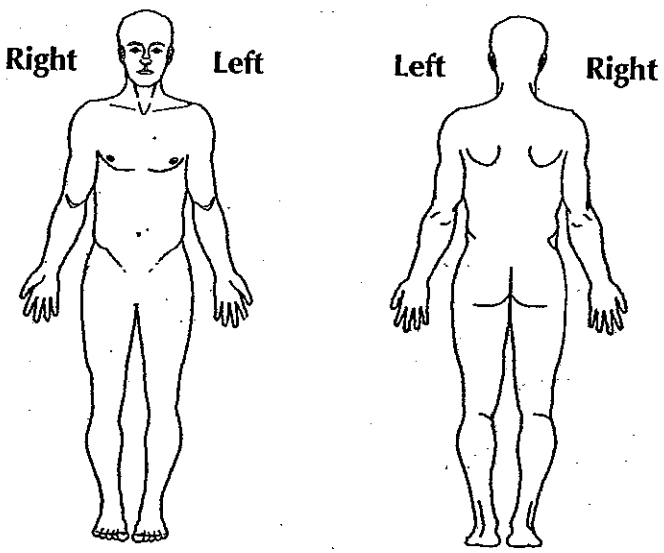
I. Sleep

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

J. Enjoyment of life

1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



What does the pain feel like?
Circle Those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

Where do you hurt? Please circle

neck	hands	hips
shoulders	mid back	knees
elbows	low back	feet

What kinds of things make your pain feel better (for example heat, medicine, rest) ?

_____

_____

What kinds of things make you pain worse (for example, walking, standing, lifting)?

_____

_____

Patient Assessment

Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:

Very Well ├──────────────────────────────────────┤ Very Poorly

How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:

No Pain ├──────────────────────────────────────┤ Pain as Bad as It Could Be

Please answer the following questions, even if you feel that they may not be related to you at this time. Answer exactly as you think or feel – there are no right or wrong answers. Check the one best answer for each question.

Activity Level **Right now, are you able to:**	**Without any difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1. Dress yourself, including tying shoelaces and doing buttons?	_____0	_____1	_____2	_____3
2. Get in and out of bed?	_____0	_____1	_____2	_____3
3. Lift a full cup or glass to your mouth?	_____0	_____1	_____2	_____3
4. Walk outdoors on flat ground?	_____0	_____1	_____2	_____3
5. Wash and dry your entire body?	_____0	_____1	_____2	_____3
6. Bend down to pick up clothing from the floor?	_____0	_____1	_____2	_____3
7. Turn regular faucets on and off?	_____0	_____1	_____2	_____3
8. Get in and out of a car, bus, train or airplane?	_____0	_____1	_____2	_____3
9. Walk two miles?	_____0	_____1	_____2	_____3
10. Participate in sports and games as you like?	_____0	_____1	_____2	_____3
11. Get a good night's sleep?	_____0	_____1.1	_____2.2	_____3.3
12. Deal with feelings of anxiety or being nervous?	_____0	_____1.1	_____2.2	_____3.3
13. Deal with feelings of depression or feeling blue?	_____0	_____1.1	_____2.2	_____3.3

For Office Use Only

GL ☐

PN ☐

FN ☐

1=0.33
2=0.67
3=1.0
4=1.33
5=1.67
6=2.0
7=2.33
8=2.67
9=3.0
10=3.33
11=3.67
12=4.0
13=4.33
14=4.67
15=5.0
16=5.33
17=5.67
18=6.0
19=6.33
20=6.67
21=7.0
22=7.33
23=7.67
24=8.0
25=8.33
26=8.67
27=9.0
28=9.33
29=9.67
30=10.0

Your Name_____ **Today's Date**_____ **Time of Day** _____

Instructions for Office Staff

Activity Level Index Scoring: For FN (questions 1-10) add total points and convert using scale on right. For PS (questions 11-13), add total points.

Visual Analog Scales: measure with metric ruler. Line is exactly 10 cm long. Scores should be recorded in cm.mm format.