Please complete front and back

Rheumatology Associates of South Texas

V3 MDH AQ

Your Name:_________________________**Date of Birth:**____________**Today's Date:** ____________________

Your: SEX: ☐ Female ☐ Male **ETHNIC GROUP:** ☐ Asian ☐ Hispanic ☐ Other ☐ Black ☐ White _________ **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Office Use Only
Wt:______ **Ht:**_______ **P:**_______
BP: ________

Preferred Language: ___English ____Spanish ____Other_________
Primary Care Physician: ____________________________
Referring Physician:__________________________ **Pharmacy #:**________________________

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Are you currently or were you recently in a skilled nursing facility or hospice? ☐ **No** ☐ **Yes**
If so please provide information to the facility on the back.

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1. Please check (✓) the **ONE** best answer for your abilities at this time:

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

2. How much pain have you had because of your condition **OVER THE PAST WEEK?** Please indicate below how severe your pain has been:

NO PAIN ○○○○○○○○○○○○○○○○○○○○○ **PAIN AS BAD AS IT COULD BE**
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. When you awakened in the morning **OVER THE PAST WEEK**, did you feel stiff? ☐ **No** ☐ **Yes**

If "**Yes**," please indicate the number of _____minutes or _____hours until you are as limber as you will be for the day

4. How do you feel **TODAY** compared to your **last appointment**? Please check (√) only one.

(1) Much better ☐ **(2) Better** ☐ **(3) the Same** ☐ **(4) Worse** ☐ **(5) Much worse** ☐

5. Considering all the ways in which illness and health conditions may affect you at this time, please Indicate below how you are doing:

VERY WELL ○○○○○○○○○○○○○○○○○○○○○ **VERY POORLY**
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

Please turn page over

FN (1) ☐

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

PN (2) ☐

PTGL (5) ☐

RAPID ☐ **(0-30)**

Category
HS=>12
MS=6.1-12
LS= 3.1-6
R= ≤3

6. Please check (√) if you have experienced any of the following over the last week:

Constitutional
- __ Fever
- __ Weight loss (>10 lbs.)
- __ Fatigue

Eyes / Mouth
- __ Dry eyes
- __ Red or inflamed eyes
- __ Ulcers in the mouth
- __ Dry mouth

Respiratory
- __ Shortness of breath
- __ Cough
- __ Pain with breathing

Cardiovascular
- __ Chest pain

Skin
- __ Rash
- __ Loss of hair

7. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least one-half hour (30 minutes)? Please check (✓) only one.

☐ **3 or more times a week** ☐ **1-2 times per week** ☐ **1-2 times per month** ☐ **Do not exercise regularly**
☐ **Cannot exercise due to disability/ handicap**

8. Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
LEFT FINGERS	☐ 0	☐1	☐2	☐3	RIGHT FINGERS	☐ 0	☐1	☐2	☐3
LEFT WRIST	☐ 0	☐1	☐2	☐3	RIGHT WRIST	☐ 0	☐1	☐2	☐3
LEFT ELBOW	☐ 0	☐1	☐2	☐3	RIGHT ELBOW	☐ 0	☐1	☐2	☐3
LEFT SHOULDER	☐ 0	☐1	☐2	☐3	RIGHT SHOULDER	☐ 0	☐1	☐2	☐3
LEFT HIP	☐ 0	☐1	☐2	☐3	RIGHT HIP	☐ 0	☐1	☐2	☐3
LEFT KNEE	☐ 0	☐1	☐2	☐3	RIGHT KNEE	☐ 0	☐1	☐2	☐3
LEFT ANKLE	☐ 0	☐1	☐2	☐3	RIGHT ANKLE	☐ 0	☐1	☐2	☐3
LEFT TOES	☐ 0	☐1	☐2	☐3	RIGHT TOES	☐ 0	☐1	☐2	☐3
NECK	☐ 0	☐1	☐2	☐3	BACK	☐ 0	☐1	☐2	☐3

9. Please write below any new drugs or medicines that have changed since your last visit.

NEW MEDICATION	DOSE	How many per day or week	DISCONTINUED MEDICATION	MEDICINE NEEDING REFILLS
1. ______________________	_____	_______	1. ______________________	1.____________________
2. ______________________	_____	_______	2. ______________________	2.____________________
3. ______________________	_____	_______	3. ______________________	3.____________________

DRUG ALLERGIES____

10. Over the last 6 months, have you had: [please check (✓)]

An operation or new illness	☐**No**	☐ **Yes**	Side effects of any drugs	☐**No**	☐ **Yes**
A patient visit or stay at a hospital	☐**No**	☐ **Yes**	Smoke cigarettes regularly	☐**No**	☐ **Yes**
An important new symptom	☐**No**	☐ **Yes**	A fall, accident or other trauma	☐**No**	☐ **Yes**

Please explain any "Yes" answers below:

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Skilled Nursing Facility/Hospice Information:

Start Date: ______________________ Leave Date: ______________________

Facility Name: ____

Address: ____

Phone #____

Case Worker's Name: ____