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** ☐ Asian ☐ Hispanic ☐ Other **GROUP**: ☐ Black ☐ White _____ **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separated

Preferred Language: ___English ____Spanish ____Other_____

Primary Care Physician: _____

LAST PCP APPT: _____ **NEXT PCP APPT:** _____

Referring Physician:_____

Pharmacy #:_____

Office Use Only

Wt:_____ **Ht:**_____ **P:**_____

BP: _____

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

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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.

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

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

Constitutional	Eyes / Mouth	Respiratory	Cardiovascular	Skin
☐ Fever	☐ Dry eyes	☐ Shortness of breath	☐ Chest pain	☐ Rash
☐ Weight loss (>10 lbs.)	☐ Red or inflamed eyes	☐ Cough		☐ Loss of hair
☐ Fatigue	☐ Ulcers in the mouth	☐ Pain with breathing		
	☐ Dry mouth			

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: _____