

RHEUMATOLOGY PATIENT FOLLOW UP FORM

Since your last visit have you had any hospitalizations or surgeries? No Yes  
If yes, please list \_\_\_\_\_  
\_\_\_\_\_

Since your last visit have you developed any NEW drug allergies? No Yes  
If yes, please list drug and type of reaction  
\_\_\_\_\_  
\_\_\_\_\_

Since your last visit have you developed any NEW medical problems? No Yes  
If yes, please list \_\_\_\_\_  
\_\_\_\_\_

Since your last visit have you developed any NEW symptoms? No Yes  
If yes, please list \_\_\_\_\_  
\_\_\_\_\_

Please circle any symptoms that you have experienced RECENTLY or CURRENTLY:

Constitutional: fever \_\_\_\_\_ degrees weight gain/loss \_\_\_\_\_ lbs fatigue weakness

Sleep disturbance: falling asleep staying asleep pain affecting sleep duration of sleep \_\_\_\_\_ hrs.

Psychosocial: anxiety depression irritability anger stress crying spells excessive worry

Musculoskeletal: joint pain joint swelling morning stiffness \_\_\_\_\_ min/hrs muscle tenderness

Skin: rashes hair loss hives sun sensitivity bruising color change Endocrine: increased thirst

Eyes: dry redness itching loss of vision Heart: chest pain palpitations high blood pressure

Ears, Nose, Mouth, Throat: dryness ulcers loss of hearing ringing in ears nosebleeds hoarseness  
trouble swallowing

Lungs: shortness of breath cough wheezing swollen legs Lymph: swollen glands anemia bleeding

Gastrointestinal: nausea vomiting diarrhea constipation heartburn abdominal pain black stools

Genitourinary: burning or difficulty urinating bloody urine urinating during night rashes/ulcers

Neurological: seizures strokes headaches dizziness numbness burning pains memory difficulties

Please list your major concerns you wish to have addressed this visit:

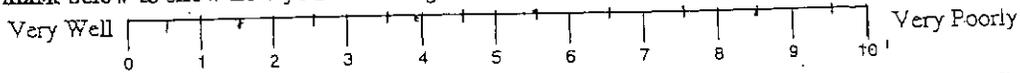
- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_

PLEASE LIST DOCTORS YOU WOULD LIKE YOUR RECORDS SENT TO:

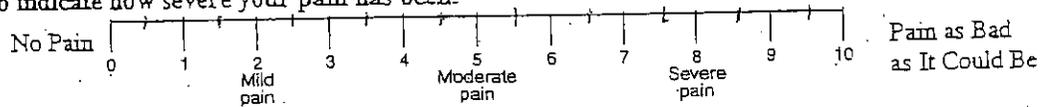
- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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:

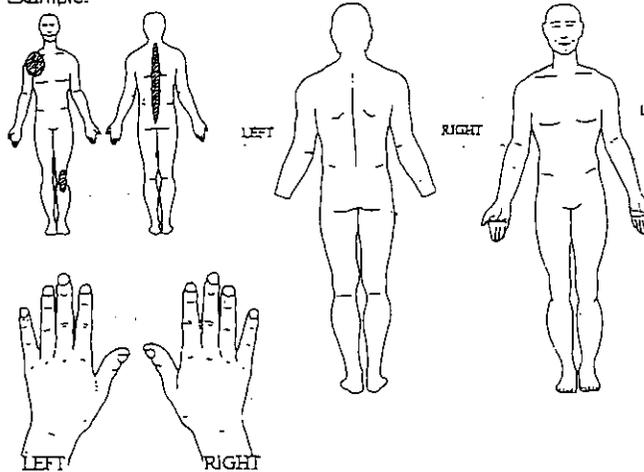


How much pain have you had because of your condition over the past week? Place a mark on the line below to indicate how severe your pain has been:



Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



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
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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

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Time of Day \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

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