



RHEUMATOLOGY RECHECK FORM

Today's Date _____ First Name _____ Last Name _____ Date of Birth _____

This questionnaire includes information not available from blood tests, x-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1. Please check the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Get in and out of bed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Lift a full cup or glass to your mouth?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Walk outdoors on flat ground?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Wash and dry your entire body?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Bend down to pick up clothing from the floor?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Turn regular faucets on and off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. Get in and out of a car, bus, train or airplane?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. Walk two miles or three kilometers, if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. Participate in recreational activities and sports as you would like, if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
k. Get a good night's sleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
l. Deal with feelings of anxiety or being nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3
m. Deal with feelings of depression or feeling blue?	<input type="checkbox"/> 0	<input type="checkbox"/> 1.1	<input type="checkbox"/> 2.2	<input type="checkbox"/> 3.3

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

NO 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 PAIN AS BAD AS IT COULD BE

3. Please check 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
a. LEFT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	j. RIGHT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. LEFT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	k. RIGHT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. LEFT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	l. RIGHT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. LEFT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	m. RIGHT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. LEFT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	n. RIGHT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. LEFT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	o. RIGHT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. LEFT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	p. RIGHT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. LEFT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	q. RIGHT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. NECK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	r. BACK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

4. 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 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 VERY POORLY

FOR OFFICE USE ONLY

1. a-j FN (0-10):

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

2. PN (0-10):


4. PTGL (0-10):

RAPID 3 (0-30):



5. Please check all symptoms you have experienced in the last MONTH:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain (>10 lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (<10 lbs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Heart pounding (palpitations) | <input type="checkbox"/> Swelling of other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression - feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety - feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain, aches or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

**FOR OFFICE
USE ONLY**
5. ROS:


6. Please list any changes in your health, medications, occupation or medical care since your last visit:

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____