PHYSICIANS' CLINIC
of Iowa, P.C.

RHEUMATOLOGY QUESTIONNAIRE

Return to Dr. _____

Date _____ Time _____

First Name _____ MI _____ Last Name _____

Date of Birth _____ Height (feet/inches) _____ Weight (pounds) _____ Gender: ☐ Male ☐ Female

Main reason for today's visit: _____

Please list the names of other health care providers you have seen for this problem: _____

Describe briefly your present symptoms (quality, location, timing, other problems): _____

Date symptoms began (approximate) _____ Diagnosis given? _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications will be listed later) _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY: At any time have you or a blood relative had any of the following?

		Yourself or Family Member?			Yourself or Family Member?
☐ Yes ☐ No	Ankylosing Spondylitis		☐ Yes ☐ No	Lupus or "SLE"	
☐ Yes ☐ No	Arthritis (type unknown)		☐ Yes ☐ No	Osteoarthritis	
☐ Yes ☐ No	Ulcerative Colitis/Crohn's		☐ Yes ☐ No	Osteoporosis	
☐ Yes ☐ No	Back or Spine Problems		☐ Yes ☐ No	Psoriatic Arthritis	
☐ Yes ☐ No	Childhood Arthritis		☐ Yes ☐ No	Psoriasis	
☐ Yes ☐ No	Gout		☐ Yes ☐ No	Rheumatoid Arthritis	

Other arthritis conditions: _____

PAST MEDICATIONS: *Review the list below of "arthritis" medications. As accurately as possible, try to remember **which** medications you have taken, **how long** you were taking the medication, the **results** of taking the medication, and list any **reactions** you may have had.*

Name of Medication	Length of Time	Please check how drug helped: A Lot	Somewhat	Not At All	Reactions
1. Aspirin					
2. Aspirin-containing product					
3. Tylenol (plain/Acetaminophen)					
4. Tylenol with Codeine					
5. Darvon/Darvocet (Propoxyphene)					
6. Feldene (Piroxicam)					
7. Indocin (Indomethacin)					
8. Motrin (Ibuprofen)					
9. Naprosyn (Naproxen)					
10. Cortisone/Prednisone					
11. Colchicine					
12. Plaquenil (Hydroxycloroquine)					
13. Methotrexate					
14. Imuran (Azathoprine)					
15. Cytoxan (Cyclophosphomide)					
16. Relafen (Nabumetone)					
17. Etodolac					

Name of Medication	Length of Time	Please check how drug helped: A Lot	Somewhat	Not At All	Reactions
18. Meloxicam					
19. Leflunomide (Arava)					
20. Humira					
21. Enbrel					
22. Cimzia					
23. Simponi					
24. Actemra					
25. Rituxan					
26. Remicade					
Other					

SOCIAL HISTORY:

Highest level of education completed: ☐ High School (No Diploma) ☐ High School Diploma ☐ Vocational School ☐ College (No Degree) ☐ College Degree ☐ Graduate Degree ☐ Other _____

Number of days you were unable to complete usual work inside or outside your home over the last 3 months because of arthritis: _____

Where do you live? ☐ House ☐ Apartment Do you exercise? _____

Do you have to climb stairs? ☐ Yes ☐ No If yes, how many? _____

Number of people in your household: _____ Relationship and age of each: _____

On the scale of 1-5 below, check the number that best describes your situation. "Most of the time I function.....

☐ 1—Very Poorly *(extreme pain/discomfort)* ☐ 2—Poorly ☐ 3—OK *(moderate pain discomfort)* ☐ 4—Well ☐ 5—Very Well *(no pain/discomfort)*

Do you use a: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last MONTH.

General:
- ☐ Yes ☐ No Confusion
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Weakness
- ☐ Yes ☐ No Fever or chills
- ☐ Yes ☐ No Tick bites followed by rash

Nervous System:
- ☐ Yes ☐ No Loss of consciousness
- ☐ Yes ☐ No Sensitivity, pain/ numbness, tingling of hands and/or feet
- ☐ Yes ☐ No Memory loss

Psychiatric:
- ☐ Yes ☐ No Mental health concerns

Ears:
- ☐ Yes ☐ No Ringing/ buzzing in ears

Eyes:
- ☐ Yes ☐ No Pain
- ☐ Yes ☐ No Redness
- ☐ Yes ☐ No Loss of vision
- ☐ Yes ☐ No Dryness
- ☐ Yes ☐ No Feels like debris in eye
- ☐ Yes ☐ No Cataracts

Nose:
- ☐ Yes ☐ No Nosebleeds
- ☐ Yes ☐ No Dryness

Mouth:
- ☐ Yes ☐ No Sore tongue
- ☐ Yes ☐ No Bleeding gums
- ☐ Yes ☐ No Loss of taste
- ☐ Yes ☐ No Dryness
- ☐ Yes ☐ No Wear dentures

Throat:
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Difficulty swallowing

Neck:
- ☐ Yes ☐ No Swollen glands
- ☐ Yes ☐ No Tender glands

Skin:
- ☐ Yes ☐ No Rash
- ☐ Yes ☐ No Hives
- ☐ Yes ☐ No Sun sensitive (allergy)
- ☐ Yes ☐ No Tightness
- ☐ Yes ☐ No Hair loss
- ☐ Yes ☐ No Color changes of hands or feet

Stomach and Intestines:
- ☐ Yes ☐ No GI bleed
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting of blood or coffee ground material
- ☐ Yes ☐ No Persistent diarrhea
- ☐ Yes ☐ No Blood in stools
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Peptic ulcer disease (GERD)

Kidney/Urine/Bladder:
- ☐ Yes ☐ No Blood in urine
- ☐ Yes ☐ No Cloudy "smoky" urine
- ☐ Yes ☐ No Discharge from penis/ vagina
- ☐ Yes ☐ No Getting up at night to urinate
- ☐ Yes ☐ No Vaginal dryness
- ☐ Yes ☐ No Rash/ulcers
- ☐ Yes ☐ No AIDS or sexually transmitted diseases
- ☐ Yes ☐ No Scrotal or testicle lumps

Blood:
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Bleeding tendency

Muscles/Joints/Bones:
- ☐ Yes ☐ No Morning stiffness
- ☐ Yes ☐ No Swollen joints
- ☐ Yes ☐ No Joint pain at rest
- ☐ Yes ☐ No Joint pain with activity
- ☐ Yes ☐ No Back pain
- ☐ Yes ☐ No Buttock pain
- ☐ Yes ☐ No Nodules on tendons or skin

Heart and Lungs:
- ☐ Yes ☐ No Sudden changes in heartbeat
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Difficulty breathing at night
- ☐ Yes ☐ No Swollen legs or feet (edema)
- ☐ Yes ☐ No Heart murmurs
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Coughing up blood
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Night sweats
- ☐ Yes ☐ No Varicose veins or phlebitis

Date of last eye exam: _____
Date of last chest X-Ray: _____
Date of last TB test: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____