# MARIETTA RHEUMATOLOGY ASSOCIATES, P.C.

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Patient Name: ______________________________ Date: ______________________

**Please place a mark (✓) on each line below to indicate your level of symptoms recently**

Joint pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint swelling on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint warmth on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint redness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint tenderness on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Joint stiffness when I awake in the mornings lasts how long on an **average** day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Back/Neck pain on an Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck tenderness on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Back/Neck stiffness when I awake in the mornings lasts how long on an **average** day?
None 0----|----|----|----|----|----|----|----|----|---- 60 Minutes or
None 0----|----|----|----|----|----|----|----|----|---- 12 Hours or
All day

Difficulty Dressing, Bathing: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty with Housework: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Yardwork: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Performed

Difficulty with Job responsibilities: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe or Not Working

Difficulty Falling Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Difficulty Staying Asleep: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Sleep Average # of Hours per night: (Include the time falling asleep through the time getting out of bed the next day)
None 0----|----|----|----|----|----|----|----|----|----10 Hours

Fatigue on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

Depressed Mood on Average day: None 0----|----|----|----|----|----|----|----|----|----10 Very Severe

**Circle/Complete the most appropriate response**

Exercise performed: None, circuit training, exercise bike, jogging, pilates, swimming, walking, water therapy, weights, yoga. Other ______________________________

Average number of days per week? 0 1 2 3 4 5 6 7 Days

How long on average day of exercise? 0 5 10 15 20 30 45 60 minutes

Medications currently given to me by Rheumatology are taken as prescribed: Yes No N/A

If No, Explain ______________________________

Medications currently given to me by Rheumatology cause problems / side effects: Yes No N/A

List side effects (if applicable) ______________________________

Any other medication changes since last visit (New or Stopped medications, change in dosing?) No Yes

If Yes, Please list ______________________________

Any new drug allergies since the last visit? No Yes

If Yes, Please list drug and reaction ______________________________

Any new Medical Diagnosis since the last visit? No Yes

If Yes, Please list Diagnosis ______________________________

**Circle all that apply: Have you experienced any of the following recently?** **Describe**

Fever. Chills. ______________________________

Skin rash. Hair loss. Bald patches on scalp. ______________________________

Headache. Loss of consciousness. Numbness. Muscle weakness. ______________________________

Eye Dryness. Eye Redness. Eye tearing. Visual changes / Loss of vision. ______________________________

Shortness of Breath. Cough. Wheeze. ______________________________

Blue/white/Purple Color changes of the fingers / toes with cold exposure. ______________________________

Dry mouth . Sores in mouth. ______________________________

Pain in chest. Difficulty in breathing at night while lying flat. Swollen legs or feet. ______________________________

Nausea. Vomiting. Diarrhea. Abdominal pain. Blood in stools. ______________________________