Rockville Internal Medicine Group

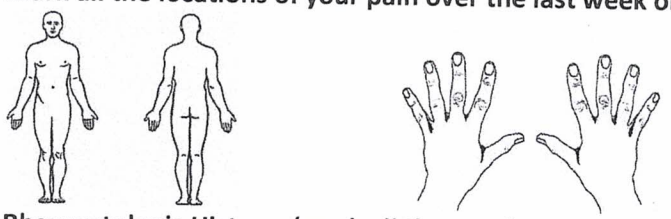
RHEUMATOLOGY QUESTIONNAIRE

Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.

Printed Patient Name: _____ **Date of Birth:** _____
Primary Medical Care Provider: _____
Referring Physician: _____
Occupation / Profession: _____
Birthplace: _____
Marital Status: Single Married Divorced **Children:** YES NO

REASON FOR VISIT: _____ **Today's Date:** _____
Describe present symptoms: _____
_____
Date symptoms began: _____ Diagnosis: _____
Previous Treatment for this problem (include physical therapy, surgery, injections, etc.):
_____
_____
List other providers you have seen for this problem: _____

Mark all the locations of your pain over the last week on the body image and hands:



Rheumatologic History: (mark all that apply to you and any blood relative - provide relationship of relative)

Yourself	Illness	Relative / Relationship		Yourself	Illness	Relative / Relationship
	Arthritis (unknown type)				Lupus or "SLE"	
	Osteoarthritis				Rheumatoid Arthritis	
	Gout				Ankylosing Spondylitis	
	Childhood Arthritis				Osteoporosis	
	Autoimmune Disease: Type:				Psoriasis	

Have you ever fractured a bone: If yes, which bones: _____
Please list any surgeries you might have had: _____
Smoking History (Mark and Complete all that apply)

Never Smoked	
Quit Smoking When -	Average Packs / Day

Do You Consume Alcohol? NO If Yes, List how much per week: _____
Do You Currently Exercise? NO If Yes, List Type and Duration: _____
How many hours do you sleep at night? ___ Do you wake up feeling reasonably well rested? _____
FOR WOMEN ONLY:
Number of Pregnancies: ____ Number of Miscarriages: _____ Have you had your ovaries removed: _____
If Post-Menopausal; Age when period stopped: _____ Have you been on hormone replacement: _____

MEDICATION ALLERGIES: **No Known Allergies** If yes, complete below:

Drug Name	Circle All That Apply to Each Drug			
	Rash	Hives	Shortness of Breath	Other -
	Rash	Hives	Shortness of Breath	Other -
	Rash	Hives	Shortness of Breath	Other -

Rockville Internal Medicine Group

RHEUMATOLOGY QUESTIONNAIRE

*Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.

Printed Patient Name: _____ Date of Birth: _____

Primary Medical Care Provider: _____

Referring Physician: _____

Occupation / Profession: _____

Birthplace: _____

Marital Status: Single Married Divorced Children: YES NO

REASON FOR VISIT: _____ Today's Date: _____

Describe present symptoms: _____

_____

Date symptoms began: _____ Diagnosis: _____

Previous Treatment for this problem (include physical therapy, surgery, injections, etc.):

_____

_____

List other providers you have seen for this problem: _____

Mark all the locations of your pain over the last week on the body image and hands:

Rheumatologic History: (mark all that apply to you and any blood relative - provide relationship of relative)

Yourself	Illness	Relative	Illness	Relative
	Arthritis (unknown type)			
	Osteoarthritis			
	Gout			
	Childhood Arthritis			
	Autoimmune Disease:			
	Type:			
			Lupus or "SLE"	
			Rheumatoid Arthritis	
			Ankylosing Spondylitis	
			Osteoporosis	
			Psoriasis	

Have you ever fractured a bone: If yes, which bone: _____

Please list any surgeries you might have had: _____

_____

Smoking History (Mark and Complete all that apply)

Never Smoked		
Quit Smoking	When -	Average Packs / Day

Do You Consume Alcohol? NO If Yes, List how much per week: _____

Do You Currently Exercise? NO If Yes, List Type and Duration: _____

How many hours do you sleep at night? ___ Do you wake up feeling reasonably well rested? _____

FOR WOMEN ONLY:

Number of Pregnancies: ____ Number of Miscarriages: ____ Have you had your ovaries removed: _____

If Post-Menopausal: Age when period stopped: _____ Have you been on hormone replacement: _____

MEDICATION ALLERGIES: No Known Allergies If yes, complete below:

Drug Name	Circle All That Apply to Each Drug	
	Rash Hives Shortness of Breath	Other -
	Rash Hives Shortness of Breath	Other -
	Rash Hives Shortness of Breath	Other -

Rockville Internal Medicine Group RHEUMATOLOGY HEALTH UPDATE

Print Patient Name: _____ Today's Date: _____

DOB: _____

MULTI-DIMENSIONAL HEALTH ASSESSMENT QUESTIONS (Copyright Health Report Services)

1. **Please answer the following questions to assess your abilities over the last week:**

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

2. **Over the past week, How much pain have you had because of your condition? Indicate below how severe your pain has been. Circle the number that reflects your level of pain:**

NO PAIN 0 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0 **PAIN AS BAD AS IT COULD BE**

3. **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 .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0 **VERY POORLY**

OFFICE USE ONLY

1. a-j FN (1-10) Score:_____	2. PN (1-10) Score:_____	3. PTGL (0-10) Score:_____
1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10.0		

Patient Printed Name: _____ **Date of Birth:**_____

CURRENT MEDICATIONS (also include aspirin, vitamins, calcium, and other supplements)**:**

NAME	DOSE	FREQUENCY	INDICATION	DURATION OF TX

VACCINES RECEIVED: (Mark all that apply)

	NAME	Administration Date	Result / Reaction if Any.
	Flu Vaccine		
	Pneumonia Vaccine		
	PPD (TB test) / BCG		
	Zostavax (Shingles Vaccine)		
	Hepatitis B		

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	**Genitourinary**	**Musculoskeletal**
Unintended Weight Loss:	Pain with Urination	Joint Pain/Swelling (list joints)/area
Amount -	Frequent Urination	1.
How long -	History of Nephritis	2.
Unintended Weight Gain:	Blood in Urine	3.
Amount -	Kidney Stones	Muscle Weakness
How long -	Discharge from penis/vagina	Muscle Pains/Aches
Fatigue	Urinary Incontinence	Morning Stiffness- Hours:
Fever	Rash / Ulcers	Minutes:
Eyes	**Gastrointestinal**	**Psychological**
Pain	Nausea / Vomiting	Anxiety
Redness	Vomiting Blood	Depression
Loss of Vision	Difficulty Swallowing	Difficulty Falling Asleep
Dryness	Heartburn/Indigestion	Difficulty Staying Asleep
Ears-Nose-Mouth-Throat	Recent Abdominal Pain	Excessive Worries
Hoarseness	Chronic Constipation	**Skin / Hair**
Difficulty Swallowing Liquids	Chronic Diarrhea	Easy Bruising
Difficulty Swallowing Solids	Bloody/Black Stools	Rash
Severe Dryness of Mouth	Bowel Incontinence	Hives
Respiratory	**Neurological**	Sun Sensitive
Shortness of breath	Headaches	Skin Tightness
Difficulty breathing at night	Seizures	Hair Loss causing bald spots
Cough	Numbness/Tingling Hands Feet	Color Changes to Hands/Feet
Coughing up blood	**Cardiovascular**	Skin Ulcers
Wheezing	Chest Pain when inhaling	**Spine**
Hematology	Heart Murmurs	Chronic/Recurrent back pain
Swollen Glands	Swollen Legs or feet	Chronic/Recurrent neck pain
Anemia	**Other Pertinent Medical History:**	
Bleeding Tendency		
Transfusion:		
When:		
Clotting Tendency		

Patient Signature: _____ **Date:**_____