



# 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?

- |                              |                             | <u>Yourself or Family Member?</u> |                              |                             | <u>Yourself or Family Member?</u> |
|------------------------------|-----------------------------|-----------------------------------|------------------------------|-----------------------------|-----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ankylosing Spondylitis _____      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus or "SLE" _____              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis (type unknown) _____    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoarthritis _____              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcerative Colitis/Crohn's _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis _____                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Back or Spine Problems _____      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psoriatic Arthritis _____         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Childhood Arthritis _____         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psoriasis _____                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout _____                        | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: |          |            | Reactions |
|------------------------------------|----------------|-------------------------------|----------|------------|-----------|
|                                    |                | A Lot                         | Somewhat | Not At All |           |
| 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 (Hydroxychloroquine) |                |                               |          |            |           |
| 13. Methotrexate                   |                |                               |          |            |           |
| 14. Imuran (Azathoprine)           |                |                               |          |            |           |
| 15. Cytoxan (Cyclophosphomide)     |                |                               |          |            |           |
| 16. Relafen (Nabumetone)           |                |                               |          |            |           |
| 17. Etodolac                       |                |                               |          |            |           |

| Name of Medication      | Length of Time | Please check how drug helped: |          |            | Reactions |
|-------------------------|----------------|-------------------------------|----------|------------|-----------|
|                         |                | A Lot                         | Somewhat | Not At All |           |
| 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: \_\_\_\_\_