PHYSICIANS' CLINIC
*of Iowa, P.C.*

# 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? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| b. Get in and out of bed? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| c. Lift a full cup or glass to your mouth? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| d. Walk outdoors on flat ground? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| e. Wash and dry your entire body? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| f. Bend down to pick up clothing from the floor? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| g. Turn regular faucets on and off? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| h. Get in and out of a car, bus, train or airplane? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| i. Walk two miles or three kilometers, if you wish? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| j. Participate in recreational activities and sports as you would like, if you wish? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 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. How much pain have you had because of your condition OVER THE PAST WEEK?** Please check how severe your pain has been:

NO PAIN 0 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 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 | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | j. RIGHT FINGERS | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| b. LEFT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | k. RIGHT WRIST | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| c. LEFT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | l. RIGHT ELBOW | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| d. LEFT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | m. RIGHT SHOULDER | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| e. LEFT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | n. RIGHT HIP | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| f. LEFT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | o. RIGHT KNEE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| g. LEFT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | p. RIGHT ANKLE | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| h. LEFT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | q. RIGHT TOES | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| i. NECK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | r. BACK | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 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 5.0 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:**

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

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**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: _____