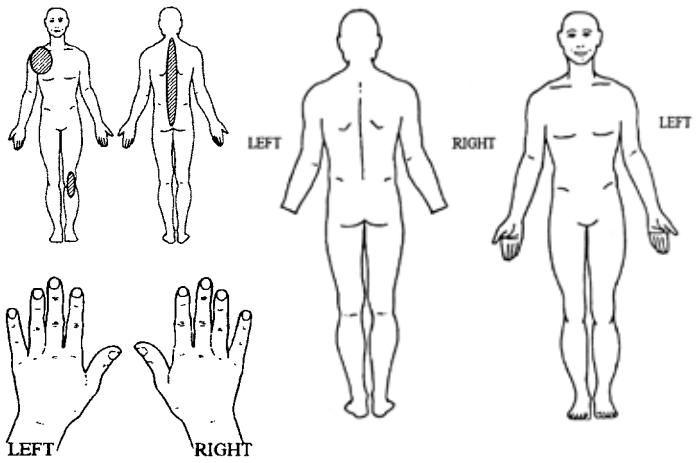
The Christ Hospital™ Physicians
Rheumatology

ESTABLISHED PATIENT QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

Since your last visit have you had any new medical problems or surgeraies? ❑ Yes ❑ No

Explain briefly: _____

Since your last visit have you had any changes in your home or work situation? ❑ Yes ❑ No

Explain briefly: _____

1. Please check the ONE best answer for your abilities at this time:

Over the last week, were you able to:	Without ANY Difficulty 0	With SOME Difficulty 1	With MUCH Difficulty 2	UNABLE to do 3
Dress yourself, including tying shoelaces and doing buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire body?				
Bend down to pick up clothing from the floor?				
Turn regular faucets on and off?				
Get in and out of a car, bus, train or airplane?				
Walk two miles or three kilometers, if you wish?				
Participate in recreational activities and sports as you would like, if you wish?				

2. How much pain have you had because of your condition OVER THE PAST WEEK?

NO ❑ SEVERE PAIN

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how well you are doing:

VERY ❑ VERY WELL

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10 POORLY

Reviewed by _____ Date _____

OFFICE USE

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)

3. PTGL

RAPID (0-30)

SCORE
>12 = High
6-12 = Moderate
<6 = Low
<3 = Remission

* R 7 3 8 2 *

Patient Name _____ **Date of Birth** _____

Symptoms (Please check all that apply)

Constitutional
- ❑ Fever/chills
- ❑ Night sweats
- ❑ Fatigue
- ❑ Weight loss
- ❑ Weight gain

Eyes
- ❑ Dry eyes
- ❑ Red eyes
- ❑ Loss of vision
- ❑ Double vision

ENT/Oral
- ❑ Loss of hearing
- ❑ Mouth ulcers/sores
- ❑ Hoarseness voice
- ❑ Dry mouth
- ❑ Trouble swallowing

Skin
- ❑ Rash
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Easy bruising
- ❑ Color changes of hands/feet in cold
- ❑ Digital ulcer/scars

Respiratory
- ❑ Cough dry/wet
- ❑ Shortness of breath
- ❑ Wheeze
- ❑ Coughing up blood
- ❑ Rib pain w/breathing

Cardiac
- ❑ Chest pain
- ❑ Swelling of legs/feet
- ❑ Irregular heart beat

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Heart burn
- ❑ Blood in stool
- ❑ Constipation
- ❑ Diarrhea

GU
- ❑ Blood in urine
- ❑ Urinary problems
- ❑ Stone problems
- ❑ Vaginal/genital ulcers

MSK
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Morning stiffness
- ❑ Muscle pain
- ❑ Muscle weakness

Neurological
- ❑ Headaches
- ❑ Dizziness
- ❑ Loss of consciousness
- ❑ Seizures
- ❑ Loss of memory

Psychiatric
- ❑ Depressed mood
- ❑ Anxious mood
- ❑ Sleep problems
- ❑ Snoring
- ❑ Problems with concentration

Any other problems not listed above:

_____

_____

_____

_____

❑ I currently do not have any symptoms listed above.

Reviewed by _____ Date _____

❑ Entire form was administered to patient. PLEASE TURN TO OTHER SIDE.