AchyJoint Rheumatology

___Fever	___Dry eyes	___Heartburn	___Burning urination
___Fatigue	___Red eyes	___Difficulty swallowing	___Skin rash
___ Weight gain/loss	___Vision changes	___Diarrhea	___Hair loss
___Dry mouth	___Shortness of breath	___ Constipation	___Bruising
___Oral Ulcers	___Chest Pain	___Fingertips change color	___Headache

1. Since the last visit I've had:	☐ Accidents/Falls?	**New Medication**	**For Female Patients:**
☐ No Problems_____	☐ Stomach Ulcer	Started /Stopped?	1. Are you Pregnant?
☐ New Diagnosis_____	☐ Eye Problem	_____	Yes or No
☐ Infection_____	☐ Cancer	_____	2. Do you Plan to become
☐ Heart and Lung Problem_____	☐ Joint Injection	_____	Become Pregnant in 6 months?
☐ Hospitalization_____	☐ Joint Surgery	_____	Yes or No

2. How much pain have you had because of your condition OVER THE PAST WEEK?
Please indicate below how severe your pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE
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

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

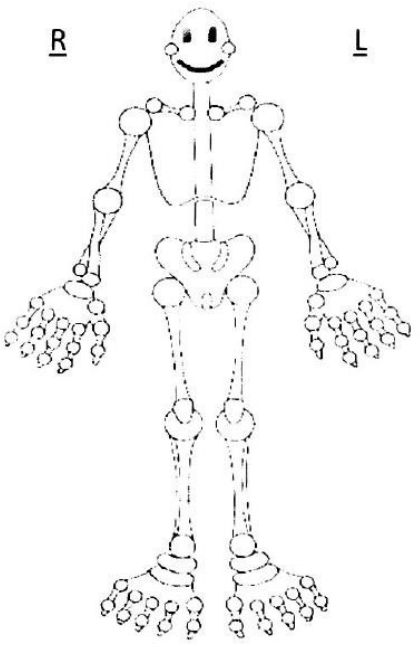
VERY WELL ○ VERY POORLY
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

4 How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS NO PROBLEM ○ FATIGUE IS A MAJOR PROBLEM
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

5 When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "**Yes**," **please indicate the number of minutes**_____, **or hours** ___

Mark or Circle the Joint or Area that Hurts



6. Comments:

Your Name_____ **Date of Birth** _____ **Today's Date** _____