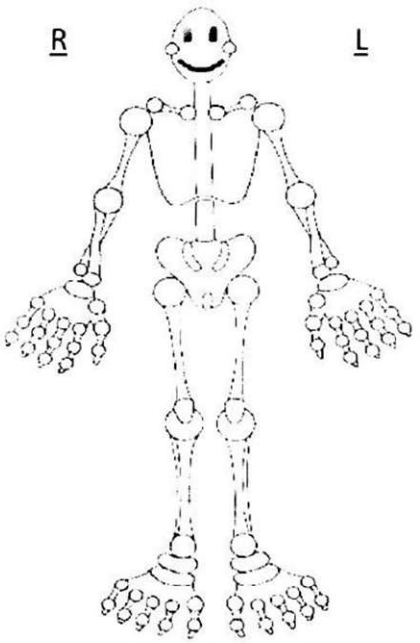
ACHYJOINT
RHEUMATOLOGY & WELLNESS CENTER

___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

Mark or Circle the Joint or Area that Hurts



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 9. 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 ___

6. Comments:

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