Orlando Arthritis and Rheumatology Clinic

Patient History Update

What has happened since you were last here?

Clinic Number	Patient Name *(First, Middle, Last)*	Date *(Month DD, YYYY)*

Since your last visit, have you?	**Yes**	**No**	**If yes, please specify**
Had any illnesses?	☐	☐	_____
Seen any health care providers?	☐	☐	_____
Had any x-ray, lab or other procedures	☐	☐	_____
Had any change in your family medical history?	☐	☐	_____
Had any change in your social history?	☐	☐	_____
Had any new allergies or reactions to medications?	☐	☐	_____
Started, changed or stopped any medications?	☐	☐	_____

New diseases or illnesses developed by relatives (parents, children, aunts, uncles, brothers, sisters)	**Changes in your social situation: Work, relationships, residence, smoking, alcohol consumption**	**New allergies or reactions to medications**

Please list any medications which are new, changed or stopped since your last visit

Name of Medication	**New, Change Or Stop** (For dose change, indicate current dosage)	**Name of prescribing doctor.** If you made the change, put Self	**Why was the medication changed or stopped?** No longer needed? No longer effective or not ever effective? Side effects (please specify)?

How Do You Feel Today as Compared to Your Last Visit Here? **1=**Much better **2**=Better **3**=Same **4**=Worse 5=Much Worse

How long is your morning stiffness (minutes)? _____ What is your worst joint?_____

Have you experiences any of the following over the LAST MONTH? (please circle)

General	**Skin**	**HEENT**	**Respiratory**	**Cardiovascular**	**Gastrointestinal**	**Genitourinary**	**Neurological**
Fever Weight loss Swollen glands	Rash Easy bruising Skin ulcers	Dry eyes Painful/red eyes Change in vision Sores in mouth or nose	Cough Wheezing Shortness of breath	Chest pain Leg swelling	Nausea/vomiting Diarrhea Blood in stools Difficulty swallowing	Pain/burning with urination Blood in urine	New headache Difficulty sleeping

For Women: Do you still have menstrual periods ☐ No ☐ Yes

If yes, when was your last menstrual period? _____

Orlando Arthritis and Rheumatology Clinic
Health Assessment Questionnaire

Clinic Number	Patient Name *(First, Middle, Last)*	Date *(Month DD, YYYY)*

We are interested in learning how your illness affects your ability to function in daily life.

Instructions: Check the box which best describes your usual abilities **over the last week.**

Are you able to:	**Without Any Difficulty (0)**	**With Some Difficulty (1)**	**With Much Difficulty (2)**	**Unable To Do (3)**
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Get on/off toilet?	☐	☐	☐	☐
Reach and get down a five pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐
Go up two or more flights of stairs?	☐	☐	☐	☐

Please mark on the line to indicate the severity of the pain.

How much pain have you had because of your illness in the past week?

No Pain ——————————— **Severe Pain**

Patient Global Assessment

Considering all the ways your disease affects you, how well are you doing overall in the last week?

Best Possible ——————————— **Worst Possible**

For Provider Only

Provider Global Assessment _____

Tender Joint Count _____ **CDAI**_____

Swollen Joint Count _____