



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

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 _____