Huntington Health Physicians

Name: ______________________________ Date: ___________

MRN: ______________________________

If you have been diagnosed with rheumatoid arthritis, please complete and answer all questions below. If you do NOT have rheumatoid arthritis, SKIP Question #1 and start with Question #2. Thank you

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:				
OVER THE LAST WEEK WERE YOU ABLE TO …	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

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. PTGE (0-10):

RAPID3 (0-30):

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

In the last week have you experienced the following symptoms? Answer with Yes (X) or No (leave blank).

Pain:	Swelling:	Fatigue:	Ringing in Ears:	Stomach Upset:	Skin Rash:	Bruising:	Difficulty Sleeping:	Cough:
Eyes Red:	Chest Pain:	Fever:	Oral Ulcers:	Diarrhea:	Skin Ulcers:	Swollen Glands:	Headache:	Shortness of Breath:
Eyes Dry:	Heart Palpitations:	Weight Loss:	Depression:					

How long is your morning stiffness (minutes)? ________ Your worst joint? ________________ Do you smoke tobacco? Yes No

Did you get your influenza vaccine this flu season? Yes No If "Yes", what date did you receive the vaccine? ________________

If "Yes", where was the vaccine received? ______________________________

Physician's Initials ___________