Western Washington Medical Group

Rheumatology - Bothell

1. Please check (✓) the ONE best answer for your abilities at this time:

At this moment, are you able to:	W/out 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?	0	1	2	3
j. Participate in sports and games as you would like?	0	1	2	3
k. Get a good night's sleep?	0	1	2	3
l. Deal with feelings of anxiety or being nervous?	0	1	2	3
m. Deal with feeings of depression or feeling blue?	0	1	2	3

2. Since your last visit, have you started or stopped a medication or therapy, seen other providers, been hospitalized, had operations, had an accident, missed work or changed jobs, had other stresses, or had family members with new illness? Yes ___ No ___ (If you answered YES, please give details on back of this sheet.)

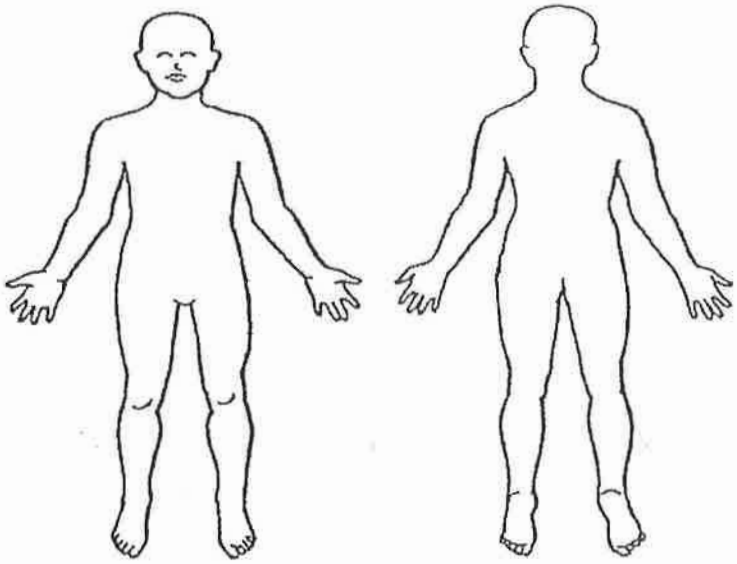
3. How much pain have you had because of your condition over the past week?
Please indicate how severe your pain has been:

NO PAIN																						PAIN AS BAD as it could be
	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	

4. 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																						NOT WELL AT ALL
	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
	0	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9	9.5	10	

Please shade all the locations of your pain over the past week on the body figures below.

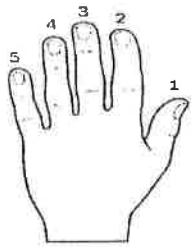


FN 0-10 ☐ PN 0-10 ☐ PTGL 0-10 ☐ RAPID3 0-30 ☐

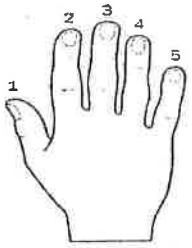
1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

Please complete back page

Please shade all the locations of your pain over the past week on the hand figures.



left hand



right hand

5. Please check (✓) if you have experienced any of the following over the last month:

___ Stiffness in AM for _____ minutes
___ Swelling in any joint (specify) _____
___ Muscle weakness
___ Muscle pain, aches, cramps
___ Unusual/new fatigue
___ Depression
___ Anxiety
___ Problems falling asleep
___ Problems staying asleep
___ Weight gain (>10 lbs)
___ Weight loss (<10 lbs)
___ Fever or night sweats
___ Swollen glands
___ Loss of appetite
___ Skin rash or hives
___ Unusual bruising or bleeding
___ Loss of hair
___ Dry eyes __ Dry mouth
___ Other eye problems
___ Problems with hearing
___ Ringing in the ears
___ Stuffy nose
___ Sores in the mouth
___ Memory or thinking problems
___ Headaches
___ Dizziness
___ Numbness or tingling of arms/legs
___ Falls
___ Balance problems
___ Fainting spells
___ Shortness of breath
___ Irregular breathing while sleeping
___ Pain in chest
___ Heart pounding (palpitations)
___ Trouble swallowing
___ Heartburn or stomach gas
___ Stomach pain or cramps
___ Nausea
___ Vomiting
___ Constipation
___ Diarrhea
___ Dark or bloody stools
___ Problems with urination
___ Gynecological (female) problems
___ Women: Menses not regular (new issue)
___ Smoking cigarettes, pipe or cigars
___ More than 2 alcoholic drinks daily

6. List any refills you need; specify ___ 30 days or ____ 90 days (check one)

7. Please list any questions you hope to discuss today.

FOR OFFICE USE ONLY:

Updated 1/17/2020