

# Welcome to the \_\_\_\_\_ Clinic.

Respond to each section below with your answer or mark. This information will help your doctor to evaluate and treat you.

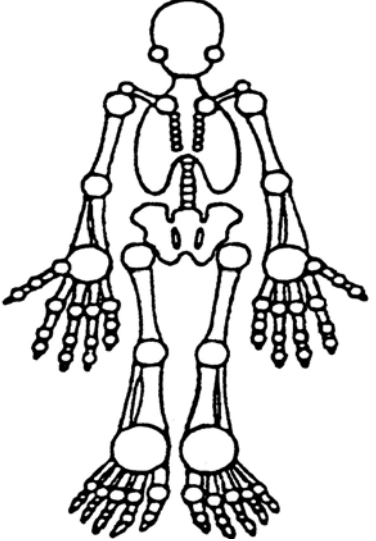
Your Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Since last visit, I'm doing (circle): Very Good Good Fair Poor Very Poor Better Worse

**What bothers you most today?**

How long is your **AM Stiffness**? None <10min 15min 30min 45min 1hr 2hr 4hr All day

Describe your night-time **Sleep** (mark box): Great Normal Fair Poor Very Poor  
 Can't Fall asleep Can't Stay Asleep Wakes Early Snoring Restless Legs Night Pain

<b>Since last visit I've had:</b> No Problems New Diagnosis _____ Infection _____ Heart or Lung Problem Hospitalization	Stomach Ulcer Accidents or Fall Eye problem Cancer Joint Injection Joint Surgery	<b>New Medicines Started?</b> _____ _____ _____	<b>Mark or Circle the Joint or Area that Hurts</b> 
	<b>Have you recently had?</b> Fever Weight loss or gain Fatigue Stiffness/ soreness Pain in muscles Weakness Skin rash Itching Hives Hair falling out Nosebleeds	Dry mouth/eyes Sore throat Sores in mouth "Cold"/ stuffy nose Sinusitis Ringing in ears Difficult swallowing Heartburn/indigestion Nausea Vomiting Diarrhea Constipation	

**In PAST WEEK, how much pain have you had?** (circle number or put a mark thru the line below)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 MOST SEVERE PAIN  
 Mild Moderate Severe

TODAY ARE YOU ABLE TO (check box)	No Difficulty	Some Difficulty	Much Difficulty	Cannot Do
Dress yourself; including laces & buttons?				
Get in and out of bed?				
Lift a full cup or glass to your mouth?				
Walk outdoors on flat ground?				
Wash and dry your entire body?				
Bend down & pick up clothing from floor?				
Turn regular faucets on and off?				
Get in and out of a car?				

Are you working? Full-time Part-time Homemaker Retired School Disabled Applying for disability  
 Who is your Primary Care Doctor (PCP)? \_\_\_\_\_ Date last PCP visit? \_\_\_\_\_  
 Do You Smoke? Yes No Will you soon have Tests/Xrays/Surgery? No Yes \_\_\_\_\_  
 What exercise do you do? None Walk Bike Pool Run Gym Weights Stretching/Yoga  
 How do you pay for medication? Insurance Co-Pay 3mos Mail-away Medicaid Cash  
 Do you need refills today? No Yes \_\_\_\_\_

Wt	BP	P	R	T
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