**Your Name:** **Birth Date:** / / **Today's Date:** / /

## SECTION 1.

**What would you like to talk about today?** ____________________

**Do you need a refill for any medication? (please list)** ____________________

## SECTION 2.

***IMPORTANT !!***
***If you don't mark either a 'Yes' or a 'No' we assume that you mean 'No'.***

| Since your last visit, have you… | No | Yes | If yes, please explain: |
|---|---|---|---|
| Started or stopped any medication or therapy? | O | O | ____________ |
| Seen other health care providers? | O | O | ____________ |
| Been hospitalized? | O | O | ____________ |
| Had an operation? | O | O | ____________ |
| Had an accident? | O | O | ____________ |
| Missed work? | O | O | ____________ |
| Changed jobs? | O | O | ____________ |
| Had other important life stresses? | O | O | ____________ |

## SECTION 3. OVER THE PAST WEEK…

| …how hard was it for you to do the following things: | Not Hard At All | A Little | Some | Very Hard | Could Not Do It |
|---|---|---|---|---|---|
| Dress yourself, including tying shoelaces and doing buttons? | O | O | O | O | O |
| Get in and out of bed? | O | O | O | O | O |
| Lift a full cup or glass of water to your mouth? | O | O | O | O | O |
| Turn regular faucets on and off? | O | O | O | O | O |
| Walk outdoors on flat ground? | O | O | O | O | O |
| Walk two miles? | O | O | O | O | O |
| Wash and dry your entire body? | O | O | O | O | O |
| Bend down to pick up clothing from the floor? | O | O | O | O | O |
| Get in and out of a car? | O | O | O | O | O |
| Participate in physical activities as you would like? | O | O | O | O | O |

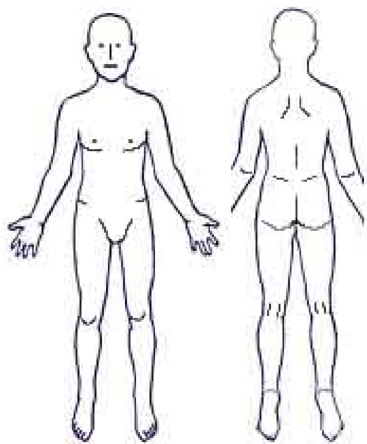
| | NO PAIN | | | | | MODERATE PAIN | | | | | WORST PAIN EVER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **OVER THE PAST WEEK**, how much pain have you had because of your condition? | O | O | O | O | O | O | O | O | O | O | O |

| | VERY WELL | | | | | FAIR | | | | | VERY POORLY |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **OVERALL**, **AT THIS TIME**, how well are you doing? | O | O | O | O | O | O | O | O | O | O | O |

## SECTION 4.

**Please shade ALL the locations of your pain IN THE PAST WEEK.**

**Put an "X" by the worst location.**



ROMANICK MD PLLC
*arthritis, fibromyalgia & immune disorders*

Rev. 9/22/10

*Thank you!*

## SECTION 5. Have you experienced any of the following IN THE PAST MONTH?

| No | Yes | | No | Yes | | No | Yes | |
|---|---|---|---|---|---|---|---|---|
| O | O | Stiffness in the AM for ______ minutes | O | O | Numbness or tingling of arms or legs | O | O | Heartburn or stomach gas |
| O | O | Paralysis of the arms or legs | O | O | Muscle pain, aches or cramps | O | O | Stomach pain or cramps |
| O | O | Gained 10 lbs or more | O | O | Muscle Weakness | O | O | Nausea |
| O | O | Lost 10 lbs or more | O | O | Trouble swallowing | O | O | Vomiting |
| O | O | Feeling sickly | O | O | Lump in your throat | O | O | Constipation |
| O | O | Fever | O | O | Problems with urination | O | O | Diarrhea |
| O | O | Headaches | O | O | Burning in sex organs | O | O | Dark/bloody stools |
| O | O | Unusual fatigue | O | O | Sexual problems | O | O | Fainting spells |
| O | O | Swollen glands | O | O | Gynecological (female) problems | O | O | Swelling of hands |
| O | O | Loss of appetite | | | | O | O | Swelling of ankles |
| O | O | Unusual bruising or bleeding | O | O | Difficulty exercising regularly | O | O | Swelling in other joints |
| O | O | Skin rash or hives | O | O | Smoking cigarettes | O | O | Joint pain |
| O | O | Other skin problems | O | O | Depression, feeling blue | O | O | Back pain |
| O | O | Hair loss | O | O | Anxiety, feeling nervous | O | O | Neck pain |
| O | O | Dry eyes | O | O | More than 2 alcoholic drinks per day | O | O | Cough |
| O | O | Other eye problems | | | | O | O | Wheezing |
| O | O | Hearing problems | O | O | Problems with thinking | O | O | Heart pounding (palpitations) |
| O | O | Ringing in the ears | O | O | Problems with memory | | | |
| O | O | Stuffy nose | O | O | Problems with sleeping | O | O | Shortness of breath |
| O | O | Sores in the mouth | O | O | Dizziness | O | O | Pain in the chest |
| O | O | Dry mouth | O | O | Losing your balance | | | |
| O | O | Problems with smell/taste | O | O | Problems with social activities | | | |