Allergy Sinus & Arthritis Clinic. PLLC

Muhammad Imran, MD Appointment:832-648-7779 Fax: 832-838-1819 www.allergysinusarthritis.net

Rheumatology Follow-Up:

Patient name: _____ Date of birth: _____

Reason for follow up: _____

Present History: (Mark if you have problems with any of the following)

Joint pain or swelling? No Yes (check all that apply below)

Location	Pain	Swelling	Right	Left
Hand Knuckles				
Finger				
Wrist				
Foot				
Toe				
Knee				
Shoulder				
Elbow				
Ankle				

Morning stiffness? If yes, How long_____ & Where_____

Considering all the ways arthritis affects you, how well are you doing (0-very well, 10- very poor):
0 1 2 3 4 5 6 7 8 9 10

	Back Pain	Hip joint/bursal pain	Shoulder joint/Bursal pain
What are your symptoms?			
Any improvement since last visit? Yes / No	Yes or No	Yes or No	Yes or No
What medications are you taking for this issue?			
Are you doing physical therapy?	Yes or No	Yes or No	Yes or No
When was your last bursal shot or back-epidural shot?			

Associated symptoms (Review of symptoms): (Circle if you have problems with any of the following)

Hair loss	DVT	Muscle pain	Interstitial Cystitis	Weight
Dry eyes	Pulmonary embolism	Non-restful sleep	Irritable bowel syn	Itching
Dry mouth	Miscarriage	Snoring	TMJ disorder	Psoriasis
Painless mouth sores	Kidney disease	Muscle spasms	Memory Issue	FHx Psoriasis
Painless nose sores	Pericardial effusion	Tingling	Concentration Issue	Gout
Face rash	Cytopenia (low wbc)	Numbness	Brain fog	Kidney stone
Photosensitivity	Fatigue)	Migraine headache	Fever, daily	Diarrhea, daily
Raynaud's	Whole body aches,Pain	Anxiety	Night sweats, daily	

Do your fingers change color when they exposed to cold temperatures? Yes No, if yes which color_____

Current Rheumatic Medications Use: (please circle)

Methotrexate	Etanercept(Enbrel)	Tocilizumab(Actemra)	Secukinumab(Cosentyx)	Adalimumab-atto (Amjevita)
Hydroxychloroquine(Plaquenil)	Adalimumab(Humira)	Tofacitinib(Xeljanz)	ixekizumab (Taltz)	
Sulfasalazine(Azulfidine)	Certolizumab(Cimzia)	Rituximab(Rituxan)	Anakinra (Kineret)	
Leflunomide (Arava)	Golimumab(Simponi)	Apremilast(Otezla)	Infliximab bio (Inflectra)	
Infliximab(Remicad)	Abatacept(Orentia)	Ustekinumab(Stelara)	Etanercept-szzs (Erelzi)	

Why **it was stopped or switched:** _____ **Dose**_____ **Helpful or Not** _____

Recent Prednisone use (last 6 months): ____No ____ Yes: why_____, when_____ & how much_____

Are you taking any Folic acid: ____No ____Yes

Monitoring Lab work: ____No ____Yes: How often:_____ Last lab date:_____

When was your Hydroxychloroquine (Plaquenil) last eye exam? _____ Normal Abnormal

Pain Medications History: (Circle all that apply)

Celebrex	Vicodin/Lortab	Ketoprofen Gel	Oxaprozin(Daypro)	Orphenadrine
Naproxen(Aleve)	Percocet/Oxycodone	Etodolac(Lodin)	Vimovo	Baclofen
Ibuprofen (Advil)	Voltaren Gel	Indomethacin	Salsalate	
Tylenol	Mobic/meloxicam	Nabumetone(Relafen)	Lidoderm patch 5%	
Tramadol	Arthrotec/Diclofenac	Piroxicam(Daypro)	Lidoderm ointment 5%	

Why it was stopped or switched: _____**Was it: Helpful Not Helpful**_____

Current Fibromyalgia Medications:

Amitriptyline (Elavil)	Gabapentin (Neurontin)	Savella (Milnacpran)	Zanaflxe (Tizanidine)	Metaxolone (Skelaxin)
Cymbalta (Duloxetine)/Venlafaxine	Lyrica (Pregabalin)	Flexeril (Cyclobenzaprine)	Carisoprodol (Soma)	Methocarbamol (Rpbaxin)

Why it was stopped or switched: _____**Was it: Helpful Not Helpful**_____

Immunization History: Last Flu shot: _____ Pneumonia shot (Pneumovax): _____ Prevnar: _____
Tetanus: _____ Shingles: _____

Are you taking Vitamin D: No Yes: Dose_____

Allergy Sinus & Arthritis Clinic. PLLC

Muhammad Imran, MD Appointment:832-648-7779 Fax: 832-838-1819 www.allergysinusarthritis.net

Your Name:_____ Today's Date: _____

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

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
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 to pick up clothing from the floor?	☐	☐	☐	☐
Turn regular faucets on and off?	☐	☐	☐	☐
Get in and out of a car, bus, train, or airplane?	☐	☐	☐	☐
Walk two miles?	☐	☐	☐	☐
Participate in sports and games as you would like?	☐	☐	☐	☐
Deal with feelings of anxiety or being nervous?	☐	☐	☐	☐
Deal with feelings of depression or feeling blue?	☐	☐	☐	☐

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 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

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 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. How do you feel **TODAY** compared to **ONE WEEK AGO?** Please check (✓) only one.

Much Better ☐ **Better** ☐ **the Same** ☐ **Worse** ☐ **Much Worse** ☐

DO NOT WRITE BELOW THIS LINE – FOR DOCTOR'S USE ONLY

VERY WELL ○○○○○○○○○○○○○○○○○○○○ VERY POORLY

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

Patient Diagnosis: _____ Provider Signature: _____

Do Not Write in this Box

1. Function:

_____

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. Pain:

_____

3. Patient Global:

_____

RAPID-3:

_____

(0-30)

Severity:
0-3: Near remission
4-6: Mild
7-12: Moderate
13-30: High
(Pincus JRh '08)

_____