Arizona Arthritis & Rheumatology Associates, P.C.

General Phone (480) 443-8400
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Progress Note

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

RACE	ETHNICITY	

BRIEFLY DESCRIBE CURRENT PROBLEMS (What hurts today?)	Any change in your personal life, new job, marital status, etc?
How long does your joint stiffness last in the morning?	Any new medical diagnosis or events since last office visit?

PLEASE CHECK ANY PROBLEMS YOU ARE HAVING. WRITE IN ANY NOT LISTED BELOW.

General: fever weight loss fatigue other

Skin: rash sun sensitive other

HEENT: dry eyes red eyes headache other

Neck: pain stiffness other

Respiratory: cough short of breath other

Breast: lump pain other

Cardiovascular: chest pain irregular heart other

Gastrointestinal: pain diarrhea other

Genitourinary: rash painful or frequent urination other

Musculoskeletal: muscle pain joint pain other

Neurological: numbness weakness tingling other

Psychiatric: depression anxiety other

Endocrine/Thyroid/Diabetes: new diagnosis other

Hematology: blood clot bleeding other

PAIN: How much pain have you had because of your arthritis IN THE PAST WEEK?
Put a mark on the scale (like this X) to show how severe your pain has been.

NO PAIN -___- **PAIN AS BAD AS IT COULD BE**
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

DISEASE ACTIVITY: Considering all the ways arthritis affects you, put a mark on the scale (like this I) to show how well you're doing.

VERY WELL -___- **VERY POORLY**
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

FATIGUE: How much of a problem has unusual fatigue or tiredness been for you IN THE PAST WEEK? Put a mark (like this I) on the line below that best describes the severity of your fatigue on a scale of 0-100.

NO PROBLEM -___- **VERY POORLY**
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

FOR STAFF USE ONLY

VARIABLE	RANGE	VALUE
Tender Joint Score	(0-28)	
Swollen Joint Score	(0-28)	
Patient Global Score	(0-28)	
Provider Global Score	(0-28)	
Add the above values to calculate score	(0-28)	

CDAI INTERPRETATION	
0.0-2.8	Remission
2.9-10.0	Low Activity
10.1-22.0	Moderate Activity
22.1-76.0	High Activity

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Please select 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
Dress yourself including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in recreational activities and sports as you would like, if you wish?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1	☐ 2	☐ 3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3

Please check in the appropriate spot to indicate the amount of pain you are having TODAY in each of the joint areas listed below:

	NONE	MILD	MODERATE	SEVERE
Left fingers	☐ 0	☐ 1	☐ 2	☐ 3
Left wrist	☐ 0	☐ 1	☐ 2	☐ 3
Left elbow	☐ 0	☐ 1	☐ 2	☐ 3
Left shoulder	☐ 0	☐ 1	☐ 2	☐ 3
Left hip	☐ 0	☐ 1	☐ 2	☐ 3
Left knee	☐ 0	☐ 1	☐ 2	☐ 3
Left ankle	☐ 0	☐ 1	☐ 2	☐ 3
Left toes	☐ 0	☐ 1	☐ 2	☐ 3
Neck	☐ 0	☐ 1	☐ 2	☐ 3

	NONE	MILD	MODERATE	SEVERE
Right fingers	☐ 0	☐ 1	☐ 2	☐ 3
Right wrist	☐ 0	☐ 1	☐ 2	☐ 3
Right elbow	☐ 0	☐ 1	☐ 2	☐ 3
Right shoulder	☐ 0	☐ 1	☐ 2	☐ 3
Right hip	☐ 0	☐ 1	☐ 2	☐ 3
Right knee	☐ 0	☐ 1	☐ 2	☐ 3
Right ankle	☐ 0	☐ 1	☐ 2	☐ 3
Right toes	☐ 0	☐ 1	☐ 2	☐ 3
Back	☐ 0	☐ 1	☐ 2	☐ 3

How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least 30 minutes?

☐ 3 or more times per week (3)	☐ 1-2 times per week (2)	☐ Cannot exercise due to disability/handicap
☐ 1-2 times per month (1)	☐ Do not exercise regularly (0)	

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Over the last six months, have you had (please check):

NO	YES		NO	YES	
☐	☐	An operation or new illness	☐	☐	Change(s) of arthritis or other medication
☐	☐	Medical emergency or overnight stay in a hospital	☐	☐	Change(s) of address
☐	☐	A fall, broken bone or other accident or trauma	☐	☐	Change(s) of marital status
☐	☐	An important new symptom or medical problem	☐	☐	Change job or work duties, quick work, retired
☐	☐	Side effect(s) of any medication or drug	☐	☐	Change of medical insurance, Medicare etc.
☐	☐	Smoking cigarettes regularly Smoking Status	☐	☐	Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you: