



Arizona Arthritis & Rheumatology Associates, P.C.

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Progress Note

PATIENT NAME		DATE OF BIRTH	TODAY'S DATE
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		Gastrointestinal: pain diarrhea other	
Skin: rash sun sensitive other		Genitourinary: rash painful or frequent urination other	
HEENT: dry eyes red eyes headache other		Musculoskeletal: muscle pain joint pain other	
Neck: pain stiffness other		Neurological: numbness weakness tingling other	
Respiratory: cough short of breath other		Psychiatric: depression anxiety other	
Breast: lump pain other		Endocrine/Thyroid/Diabetes: new diagnosis other	
Cardiovascular: chest pain irregular heart other		Hematology: blood clot bleeding other	
<p>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.</p> <p>NO PAIN - 0 - 5 - 10 - 15 - 20 - 25 - 30 - 35 - 40 - 45 - 50 - 55 - 60 - 65 - 70 - 75 - 80 - 85 - 90 - 95 - 100 - PAIN AS BAD AS IT COULD BE</p>			
<p>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.</p> <p>VERY WELL - 0 - 5 - 10 - 15 - 20 - 25 - 30 - 35 - 40 - 45 - 50 - 55 - 60 - 65 - 70 - 75 - 80 - 85 - 90 - 95 - 100 - VERY POORLY</p>			
<p>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.</p> <p>NO PROBLEM - 0 - 5 - 10 - 15 - 20 - 25 - 30 - 35 - 40 - 45 - 50 - 55 - 60 - 65 - 70 - 75 - 80 - 85 - 90 - 95 - 100 - VERY POORLY</p>			

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?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Get in and out of bed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lift a full cup or glass to your mouth?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walk outdoors on flat ground?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Wash your entire body?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Bend down to pick up clothing from the floor?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Turn faucets on and off?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Get in and out of a car, bus, or airplane?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Walk two miles if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Participate in recreational activities and sports as you would like, if you wish?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Get a good night's sleep?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Deal with feelings of anxiety or being nervous?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Deal with feelings of depression or feeling blue?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left wrist	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left elbow	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left shoulder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left hip	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left knee	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left ankle	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Left toes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Neck	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right fingers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right wrist	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right elbow	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right shoulder	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right hip	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right knee	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right ankle	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Right toes	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Back	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

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

<input type="checkbox"/> 3 or more times per week (3)	<input type="checkbox"/> 1-2 times per week (2)	<input type="checkbox"/> Cannot exercise due to disability/handicap
<input type="checkbox"/> 1-2 times per month (1)	<input type="checkbox"/> Do not exercise regularly (0)	



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

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

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