RHEUMATOLOGY ASSOCIATES

Dear Patient,

We are delighted that you have chosen our practice for your care, and we look forward to your visit.

Please arrive at least 30 minutes prior to your appointment time to allow us sufficient time to process your paperwork. For future follow up appointments, please arrive 15 minutes prior to your appointment time.

To expedite our check in process, please complete the enclosed paperwork prior to your appointment. When you arrive at our office, please present your completed paperwork, photo ID, and your insurance cards.

If your insurance plan requires a referral, it is your responsibility to contact your primary care provider and ensure they have forwarded our office a valid referral. We may not be able to see you if a referral is not on file with our office by your scheduled appointment date.

For your convenience on any money due, we accept cash, personal checks, Master Card, Visa, American Express, and Discover Card.

For more information about our practice, please visit us at **www.dfwra.com.**

If you have any questions about this notice, please contact:

Patient Services Manager: Mikaela Champagne
Email: patientservices@dfwra.com

RA RHEUMATOLOGY ASSOCIATES

Notice of Privacy Practices

As Required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

A. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. This can be done by visiting our release of information service provider, HealthMark Group at **https://requestmanager.healthmark-group.com/register.**
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us, in writing, to correct health information you believe is incorrect or incomplete.
- We may say "no" to your request, but if we do, we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us, in writing to contact you in a specific way.
  Examples: Alternate telephone number or address, email, asking us to refrain from leaving messages on answering machines or from mailing information to you.
- We will say "yes" to all reasonable requests.
  Example of unreasonable requests: Those that would be too difficult technologically or practically for the practice to accommodate.

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Ask us to limit what we use or share

- You can ask us, in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if we believe it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting), in writing of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures outside of those related to treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
  Examples of disclosures outside the scope of treatment, payment, and health care operations: A list of times we shared your Protected Health Information (PHI) with family or friends (as directed from your authorization form.)

Get a copy of this privacy notice

You can ask for a paper or electronic copy of this notice at any time, and we will provide you with it promptly. It can be requested via encrypted email, fax, mail, in person or through HealthMark Group electronically.

Choose someone to act for you

- If you have appointed someone as your Legal Representative or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will ask to see the certified copy of the order of appointment.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at

  Patient Services Manager: Mikaela Champagne
  Email: patientservices@dfwra.com

- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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B. Your Choices

For certain health information, you can tell us your choices. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to designate who we can share your information with.
Example: Family, close friends, or others involved in your care.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

C. Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other medical professionals related to your care.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
Example: Appointment reminders

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information?

We are allowed or required to share your information in other ways such as:

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- **Public health and safety issues**
- **Research**
- **Compliance with the law**
- **Inmates**
- **Respond to organ and tissue donation requests**
- **Work with a medical examiner or funeral director**
- **Address law enforcement and other government requests including Military and Veteran Authorities**
- **Respond to court orders including subpoenas or other legal actions**

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at **www.dfwra.com**.

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Patient & Guarantor Responsibilities Insurance Disclaimer

I (name of patient/guarantor) _____ understand that if my insurance does not pay for my office visit or any other services performed for any reason, I remain fully responsible to pay for all services provided. It is the patient/guarantor's responsibility to understand how their insurance coverage works.

Initial here: _____

___ It is the patient/guarantor's responsibility to determine if their provider/practice is IN or OUT of network with their insurance by calling their insurance company. Patient/guarantor is still responsible to pay for all services rendered even if the provider/practice is OUT of network or services are non-covered.

___ It is the patient/guarantor's responsibility to update our office every time their insurance coverage changes, lapses, or terminates prior to any services rendered.

___ The Patient/Guarantor understands that private pay fees or any fees separate from insurance are subject to change without notice.

By signing below, I hereby acknowledge that I have read, understood, and agree to all the above Patient/Guarantor responsibilities, Insurance Disclaimer & Private Pay policies of Rheumatology Associates.

Patient Signature: _____

Date: _____

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Cancellation/No Show Policy

A “no-show” is someone who misses an appointment without notifying the office a minimum of one business day prior. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show”. A total of 2 “no-show” appointments within the past 12 months, may result in being discharged from the practice.

Patients are expected to keep their scheduled appointments. In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to show up for a scheduled appointment. If you need to cancel or reschedule your appointment, please contact our office at 214-540-0700 no later than 24 hours prior to your appointment time or you will be charged a $50 no show fee.

Exception: Notification for Monday appointments should be given no later than 12:00 pm on the Friday before your appointment).

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8144 WALNUT HILL LANE
SUITE 800
DALLAS, TX 75231

(214) 540-0700 ← MAIN
(214) 540-0701 ← FAX
DFWRA.COM ← WEB

New Insurance

Today, _____ I am presenting new insurance for my appointment with Dr. _____ at Rheumatology Associates. I understand that it is my responsibility to ensure that a valid referral if one is required has been submitted to my insurance by my current PCP for today's visit.

If a referral has not been obtained, I will be responsible for all charges incurred at today's visit, including labs and x-rays.

_____

Patients signature Date

_____

Witness Date

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Name _____ **Cell #** _____
E-Mail _____ **DOB** _____

Receipt of Notice of Privacy Practices

I, _____, have received a copy of Rheumatology Associates' Notice of Privacy Practices.

_____
Patient Signature

Patient Request Regarding Health Information Release

(Friends/Family only – Not physicians)

Who to Contact

By completing and signing this document I hereby give permission to Rheumatology Associates to disclose as well as discuss any Protected Health Information related to my medical condition(s) with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **I do not wish to give access to my Protected Health Information to anyone besides myself regarding my medical condition**

How to Contact
Note that you are responsible for any charges incurred in receiving our communications.

Alternate Form of Communication:

_____

_____
Patient Signature Date

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Legal Representative

If the patient has a legal representative who will be signing these forms for them please fill out the information below.

Legal Representative Name	**Legal Representative Signature**
Legal Representative E-Mail	**Legal Representative Cellphone #**

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Receipt of Cancellation Policy

I have received and understand the Rheumatology Associates policy and definitions regarding cancellations. _____ (*initials*)

Insurance Authorization

I hereby authorize any and all insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I understand that if my account should be turned over to a collection agency that I will be responsible for any fees incurred, up to and including 35% of the unpaid balance. I also authorize the physician to release any information required by my insurance company. _____ (*initials*)

Consent to Obtain External Prescription History

I authorize Rheumatology Associates and its providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit manager may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. _____ (*initials*)

General Authorization for Treatment

I authorize physicians, nurse practitioners and/or physician assistants of **Rheumatology Associates** who attend to me, their assistants, including those employed by **Rheumatology Associates** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ (*initials*)

Additional Treatment Opportunities

The doctors at Rheumatology Associates are involved in research that is designed to lead to better treatments for the types of medical problems experienced by the people who come to this clinic. As such, if they feel there is an opportunity that would be medically appropriate for you, you may be contacted by a qualified professional on their staff.

Patient Signature: _____ Date: _____

RHEUMATOLOGY ASSOCIATES

Patient History Form

Date of first appointment:____/____/____ Time of appointment:_____ Birthplace:_____
(MONTH DAY YEAR)

Name:_____ Birthdate:____/____/____
(LAST FIRST MIDDLE INITIAL MAIDEN) (MONTH DAY YEAR)

Address:_____ Age:_____ Sex: ☐F ☐M
(STREET APT#)

_____ Telephone: Home (____) _____
(CITY STATE ZIP) Work (____) _____

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, Name: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

_____

Date symptoms began (approximate): _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later)

_____

_____

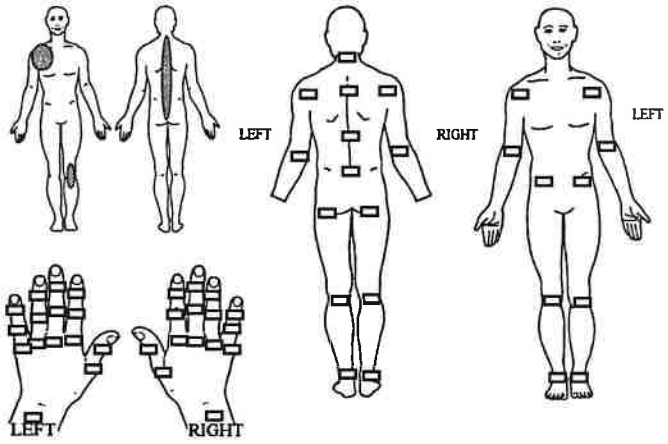
Please list the names of other practitioners you have seen for this problem:

_____

Diagnosis given:_____

Please indicate all the locations of your pain **over the past week** on the **body figures** and **hands.**

Example:



RHEUMATIC DISEASE (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
	Fibromyalgia			Chronic fatigue syndrome	
Other arthritis conditions:					

REVIEW OF SYSTEMS

As you review the following list, please check any of those problems which have significantly affected you.

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____Minutes_____Hours
- ❑ Joint pain
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____
_____
_____
_____
_____

- ❑ Muscle weakness
- ❑ Muscle tenderness

Constitutional

- ❑ Generalized weakness
- ❑ Fatigue
- ❑ Fever or chills
- ❑ Night sweats
- ❑ Recent weight loss
  amount _____
- ❑ Recent weight gain
  amount _____

Eyes

- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Redness
- ❑ Pain
- ❑ Dryness
- ❑ Feels like something in the eye
- ❑ Itching eyes

Dermatology

- ❑ Thickness
- ❑ Tightness
- ❑ Rash
- ❑ Unexpected hair loss
- ❑ Sun sensitive (sun allergy)
- ❑ Redness
- ❑ Hives
- ❑ Nodules/bumps
- ❑ Nail pits

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal pain
- ❑ Heartburn
- ❑ Diarrhea
- ❑ Mucus in stools
- ❑ Unusual constipation
- ❑ Blood in stools
- ❑ Black/tarry stools

Genitourinary

- ❑ Difficulty urinating
- ❑ Blood in urine
- ❑ Pain or burning on urination
- ❑ Pus in urine
- ❑ Cloudy urine
- ❑ Sexual difficulties
- ❑ Genital rash/ulcers

For Women Only:

- ❑ Vaginal dryness
- ❑ Vaginal discharge

Date of last period?_____/_____/_____/
Number of pregnancies? _____
Number of miscarriages? _____

For Men Only:

- ❑ Discharge from penis
- ❑ Prostate trouble

Respiratory

- ❑ Shortness of breath
- ❑ Cough
- ❑ Difficulty breathing at night
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Neurological System

- ❑ Numbness or tingling in hands
- ❑ Numbness or tingling in feet
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Cramping in legs at night
- ❑ Memory loss

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Blood clot in artery, vein, or lung
- ❑ Bleeding tendency
- ❑ Enlarged lymph nodes
- ❑ Anemia
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Ears–Nose–Mouth–Throat

- ❑ Dryness of mouth
- ❑ Sinus pain
- ❑ Difficulty swallowing
- ❑ Sores in mouth
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Bleeding gums
- ❑ Loss of taste
- ❑ Frequent sore throats
- ❑ Hoarseness

Cardiovascular

- ❑ Chest pain
- ❑ Difficulty in breathing at night
- ❑ Cramping in calves when walking
- ❑ Swollen legs or feet
- ❑ Color changes of hands in the cold
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Heart murmurs

Please state the date of your last:

Bone Densitometry____/____/____ Mammogram____/____/____ Eye exam_ / / _____ Chest x–ray / / _____

Tuberculosis Test____/____/____ Flu Vaccine____/____/____ Pneumonia Vaccine____/____/____

Tetanus Vaccine____/____/____ Shingles Vaccine____/____/____ Hepatitis B Vaccine____/____/____

YOUR PAST MEDICAL HISTORY: Have **YOU** ever been diagnosed with any of the following diseases?

❑ Cancer/Leukemia/Lymphoma	❑ Heart Disease	❑ Diabetes	❑ High blood pressure	❑ High Cholesterol	❑ Stroke
❑ Emphysema/COPD/Asthma	❑ Kidney disease	❑ Thyroid disease	❑ Jaundice/Hepatitis	❑ Tuberculosis	❑ Pneumonia
❑ HIV/ AIDS	❑ Headaches/Migraines	❑ Depression	❑ Nervous Breakdown	❑ Glaucoma	❑ Anemia
❑ Rheumatic Fever	❑ Epilepsy	❑ Psoriasis	❑ Colitis	❑ Iritis/Uveitis	❑ Sarcoidosis

Other significant illness (not listed above):_____

Previous Operations/ Surgical History

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe:_____

Any other serious injuries? ❑ No ❑ Yes Describe:_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Year of Birth	Health	Age at Death	Cause
Father				
Mother				

Number of sisters____Number living____Number deceased____Number of brothers____Number living____Number deceased____

Number of daughters____Number living____Number deceased___Number of sons____Number living____Number deceased____

Health of children: _____

Do you know of any close blood relative (parent, sibling or child) who has or had: (check and give relationship)

❑ Cancer _____	❑ Heart disease _____	❑ Rheumatic fever_____	❑ Tuberculosis __
❑ Leukemia _____	❑ High blood pressure _____	❑ Epilepsy_____	❑ Diabetes _____
❑ Stroke _____	❑ Bleeding tendency _____	❑ Asthma _____	❑ Goiter _____
❑ Colitis _____	❑ Alcoholism_____	❑ Psoriasis _____	

SOCIAL HISTORY:

Marital Status: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age_____ Major Illnesses_____

How many people in household?_____Relationship and age of each _____

Education (circle highest level attended):

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation_____Number of hours worked/average per week _____

Do you drink caffeinated beverage? ❑ No ❑ Yes Cups/glasses per day?_____

Do you smoke? ❑No ❑Yes Amount per day_____ ❑ Previous smoker? How long ago?_____

Do you drink alcohol? ❑ No ❑ Yes Number per week_____Has anyone ever told you to cut down on your drinking? ❑ No ❑ Yes

Recreational drug use? ❑ No ❑ Yes If yes please list_____

Do you exercise regularly? ❑ **No** ❑ **Yes** Frequency_____Please describe _____

MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what? _____

_____

Type of reaction: _____

PRESENT MEDICATIONS (List any medications you are taking. **INCLUDE** Over the Counter Medications as well, such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐
9.			☐	☐	☐
10.			☐	☐	☐

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped? A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Ansaid (flurbiprofen)		☐	☐	☐	
Arthrotec (diclofenac + misoprostil)		☐	☐	☐	
Aspirin (including coated aspirin)		☐	☐	☐	
Celebrex (celecoxib)		☐	☐	☐	
Daypro (oxaprozin)		☐	☐	☐	
Dolobid (diflunisal)		☐	☐	☐	
Feldene (piroxicam)		☐	☐	☐	
Indocin (indomethacin)		☐	☐	☐	
Lodine (etodolac)		☐	☐	☐	
Mobic (meloxicam)		☐	☐	☐	
Motrin (ibupoprofen)		☐	☐	☐	
Naprosyn (naproxen)		☐	☐	☐	
Oruvail (ketoprofen)		☐	☐	☐	
Voltaren (diclofenac)		☐	☐	☐	
Other_____		☐	☐	☐	
Pain Relievers					
Acetaminophen (Tylenol)		☐	☐	☐	
Codeine (Tylenol 3)		☐	☐	☐	
Hydrocodone (Vicodin, Lortab, Norco)		☐	☐	☐	
Ultram/Ultracet (tramadol)		☐	☐	☐	
Corticosteroids					
Decadron (dexamethasone)		☐	☐	☐	
Medrol dose pack (methylprednisolone)		☐	☐	☐	
Prednisone		☐	☐	☐	
Cortisone injection (where)_____		☐	☐	☐	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Arava (leflunomide)		☐	☐	☐	
Atabrine (quinacrine)		☐	☐	☐	
Azulfidine (sulfasalazine)		☐	☐	☐	
CellCept (mycophenolate mofetil)		☐	☐	☐	

DMARDS - Continued					
Cytoxan (cyclophosphamide)		☐	☐	☐	
Imuran (azathioprine)		☐	☐	☐	
Methotrexate (rheumatrex)		☐	☐	☐	
Neoral or Sandimmune (Cyclosporine A)		☐	☐	☐	
Plaquenil (hydroxychloroquine)		☐	☐	☐	
Biologics					
Actemra (tocilizumab)		☐	☐	☐	
Cimzia (certolizumab)		☐	☐	☐	
Enbrel (etanercept)		☐	☐	☐	
Humira (adalimumab)		☐	☐	☐	
Kineret (anakinra)		☐	☐	☐	
Orencia (abatacept)		☐	☐	☐	
Remicade (Infliximab)		☐	☐	☐	
Rituxan (rituximab):		☐	☐	☐	
Simponi (golimumab)		☐	☐	☐	
Osteoporosis Medications					
Actonel (risedronate)		☐	☐	☐	
Boniva (ibandronate)		☐	☐	☐	
Estrogen (Premarin, etc.)		☐	☐	☐	
Evista (raloxifene)		☐	☐	☐	
Forteo (teriparatide)		☐	☐	☐	
Fosamax (alendronate)		☐	☐	☐	
Miacalcin nasal spray (calcitonin)		☐	☐	☐	
Prolia (denosumab)		☐	☐	☐	
Reclast (zoledronic acid)		☐	☐	☐	
Gout Medications					
Zyloprim (allopurinol)		☐	☐	☐	
Colcrys (colchicine)		☐	☐	☐	
Benemid (probenecid)		☐	☐	☐	
Uloric (febuxostat)		☐	☐	☐	
Krystexxa (pegloticase)		☐	☐	☐	
Others					
Hyalgan/Synvisc/Orthovisc/Euflexxa injections		☐	☐	☐	
Cymbalta (dyloxetine)		☐	☐	☐	
Lyrica (pregabalin)		☐	☐	☐	
Neurontin (gabapentin)		☐	☐	☐	
Savella (milnacipran)		☐	☐	☐	
Muscle Relaxers		☐	☐	☐	
Sleep Medication		☐	☐	☐	
Other anti-depressants:					

Have you participated in any clinical trials for new medications? ☐ Yes ☐ No If yes, list:

ACTIVITIES OF DAILY LIVING

Who does most of the housework?_____Who does most of the shopping?_____Who does most of the yard work? _____

Because of health problems do you have difficulty: (Please check the appropriate response for each question.)	**Without ANY difficulty**	**With SOME difficulty**	**With MUCH difficulty**	**UNABLE to do**
1. Dress yourself, including tying shoelaces and doing buttons?	☐0	☐1	☐2	☐3
2. Get in and out of bed?	☐0	☐1	☐2	☐3
3. Lift a full cup or glass to your mouth?	☐0	☐1	☐2	☐3
4. Walk outdoors on flat ground?	☐0	☐1	☐2	☐3
5. Wash and dry your entire body?	☐0	☐1	☐2	☐3
6. Bend down to pick up clothing from the floor?	☐0	☐1	☐2	☐3
7. Turn regular faucets on and off?	☐0	☐1	☐2	☐3
8. Get in and out of a car, bus, train, or airplane?	☐0	☐1	☐2	☐3
9. Reaching behind your head?	☐0	☐1	☐2	☐3
10. Reaching behind your back?	☐0	☐1	☐2	☐3
11. Going to sleep?	☐0	☐1	☐2	☐3
12. Staying asleep due to pain?	☐0	☐1	☐2	☐3
13. Obtaining restful sleep?	☐0	☐1	☐2	☐3
14. Climbing stairs?	☐0	☐1	☐2	☐3
15. Descending stairs?	☐0	☐1	☐2	☐3
16. Working?	☐0	☐1	☐2	☐3
17. Getting along with family members?	☐0	☐1	☐2	☐3
18. Engaging in leisure time activities?	☐0	☐1	☐2	☐3

What is the hardest thing for you to do?_____

Do you use a c☐e, cr☐es, w☐er, or a wh☐chair? (check all that apply)

Are you receiving disability?..... Yes ❑ No ❑ Are you applying for disability?.....Yes ❑ No ❑

Do you have a medically related lawsuit pending?.....Yes ❑ No ❑

Considering that all of the ways your arthritis has affected you over the past week, please place a vertical mark on the line below to show how you are feeling:

VERY GOOD ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ VERY POOR

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Please circle on line below.

NO PROBLEM ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ MAJOR PROBLEM

How much pain have you had because of your condition OVER THE PAST WEEK? Please circle on the line below.

NONE ☐—☐—☐—☐—☐—☐—☐—☐—☐—☐—☐ AS BAD AS IT COULD BE