

**Rheumatology Screening Clinic
Initial Assessment Form**

Date: _____

What is your marital status (circle)? Single Married Common-law Widowed Divorced Separated

How many children do you have? _____

What is your Occupation? _____ Are you on Disability? YES NO

What is your Drug Plan: Private Insurance Over 65 Government Ontario Drug Benefits Other

Past Medical History

1. Do you have or have you had any problems relating to your ...?

- Eyes
- Throat
- Stomach
- Muscles
- Nose
- Heart
- Liver
- Bones
- Mouth/jaw
- Chest
- Bowels
- Joints
- Ears
- Lungs
- Kidneys/Bladder
- Nerves
- Head/Brain
- Thyroid
- Pregnancy (miscarriage)

2. Do you have or have you had any of the following illnesses?

- Heart Attack / Angina
- TIA / Stroke
- High Blood Pressure
- Diabetes
- Crohn's / Uclerative Colitis
- Thyroid Disease
- Haemochromatosis
- High Cholesterol
- Tuberculosis
- Depression
- Osteoporosis
- Hepatitis
- Psoriasis
- Other: _____

3. Have you ever had a Stomach Ulcer or Bleeding? YES NO

a. If YES, what year did you have this: _____

b. How was it diagnosed: Scope Barium X-ray Don't Know

4. Have you ever had any surgeries/operations? YES (please list) NO

5. Please list any prescription or non-prescription
MEDICATIONS you are taking now:

What NSAIDs have you tried?

Medication Name	Dose/Amount	How Often

- Celebrex
- Vioxx
- Bextra
- Mobicox
- Naprosyn
- Arthrotec
- Advil/Motrin
- Indocid
- Voltaren
- Surgam
- Feldene
- Relafen

6. Do you have any ALLERGIES to Medications? YES NO

a. If YES, please list the medication and describe what happens?

i. _____

ii. _____

iii. _____

7. Do you SMOKE cigarettes? Never Used to, but quit Yes, still do

a. Number of years smoked: _____

b. Number of packs smoked per day: _____

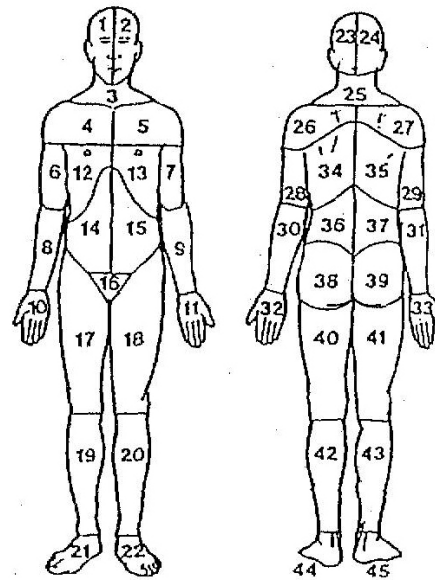
8. Do you drink Alcohol? Never Yes

a. Number of drinks per week: _____

9. Do any of your immediate family or distant family relatives have any of the following?

- Rheumatoid Arthritis
- Lupus
- Gout
- Blood clots
- Raynaud's Phenomenon
- Osteoarthritis
- Other types of Arthritis
- Psoriasis
- Cancer
- Bleeding problems
- Low Back Pain
- Osteoporosis
- Heart Disease
- Fibromyalgia
- Diabetes

10. Please shade in the following diagram to show where you have had pain over the past month.



Thank-You for completing the questionnaire, DO NOT WRITE BELOW THIS LINE

History of Presenting Illness

Previous Investigations

Previous Treatment

Rheumatologic & General Review of Systems

- Weight Appetite Sleep Fatigue/Energy AM Stiffness
- Nodules / Nodes Raynaud's Dry Eyes Dry Mouth Iritis Conjunctivitis Psoriasis or FH
- LBP / FH LBP IBD Prodromal Illness Dactylitis Enthesitis Carpal Tunnel
- Oral / Nasal Ulcers Alopecia **CNS** Malar Rash Other Rashes Photosensitivity
- Pleurisy Miscarriages Thrombosis **HTN**
- FH Gout Diuretics Dyslipidemia Diet Renal Stones
- Heart (CAD)** **Lungs (SOB)** **Kidneys** **Liver** **Bowels (PUD)**

*Vertebral Compression Fracture Fragility Fracture after Age 40 Family Hx of Osteoporotic Fracture Steroids (> 3 months)
 Malabsorption Hyperparathyroidism Propensity to fall Osteopenia on radiographs Hypogonadism Hyperthyroidism
 Anticonvulsant therapy Low Ca intake Smoker Alcohol Weight < 57 kg or Wt loss > 10*

Physical Examination

VITALS

Pulse _____ *BP (R)* _____ *BP(L)* _____ *Height* _____ *Weight* _____ *Temp* _____

H&N (*inspection of hair & scalp, eyes, mouth, thyroid*)

Normal Comment: _____

Abnormal _____

LYMPH NODES (*palpation*)

Normal Comment: _____

Abnormal _____

SKIN & NAILS (*inspection for thickening, rashes, nodules, telangiectasia, livedo, vasculitic changes*)

Normal Comment: _____

Abnormal _____

CVS (*heart sounds, murmurs, rhythm, edema, peripheral vascular exam*)

Normal Comment: _____

Abnormal _____

CHEST (*auscultation, percussion*)

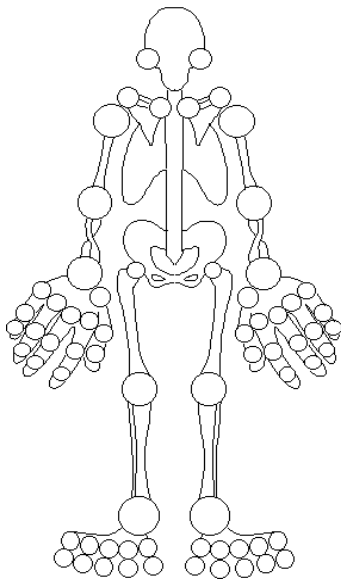
Normal Comment: _____

Abnormal _____

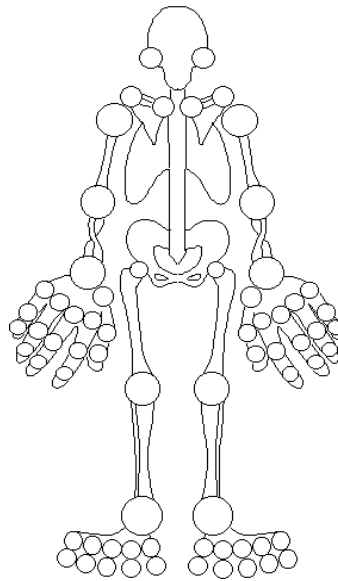
ABD (*auscultation, palpation, percussion*)

Normal Comment: _____

Abnormal _____



Tender



Swollen / Damaged

C-Spine

T-Spine

L-Spine

Mod Schober _____ (20) cm

Fingertip to Floor _____ cm

RLF _____ cm **LLF** _____ cm

CE _____ cm **OWD** _____ cm

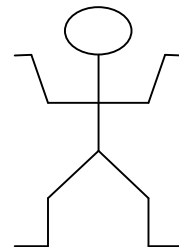
FMTF

Anterior = _____ / 6

Posterior = _____ / 6

Inferior = _____ / 6

TOTAL = _____ / 18



IMPRESSION

PLAN