

9. Please check (✓) if you have experienced any of the following over the last month:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain (>10 lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (>10 lbs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Heart pounding (palpitations) | <input type="checkbox"/> Swelling in other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression - feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety - feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain, aches, or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

Please check (✓) here if you have had none of the above over the last month: _____.

10. Please place a check (✓) in the appropriate box to indicate how much pain you are having today in each joint area:

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>		<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
LEFT FINGERS	<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
LEFT WRIST	<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
LEFT ELBOW	<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
LEFT SHOULDER	<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
LEFT HIP	<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
LEFT KNEE	<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
LEFT ANKLE	<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
LEFT TOES	<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
NECK	<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

11. Please list all the medications you have taken over the last 2 weeks (if more than 6, please list on a separate page).

<u>NAME OF MEDICINE</u>	<u>DOSE</u>	<u>NAME OF MEDICINE</u>	<u>DOSE</u>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Allergies to medications: _____

12. What is the name of the condition for which you are here today? _____

Year _____ or your age _____ when you first had symptoms of this condition.

Year _____ or your age _____ when you were diagnosed with this condition.

13. How many years of school have you completed? Please circle the number of years of school.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

14. At this time, are you? Please check (✓) all that apply:

- Working full-time, Working part-time, Student, Homemaker—full-time, Unemployed,
 Retired, Disabled, Other (describe): _____ Your occupation is/was _____

Your: **SEX:** Female Male **ETHNIC GROUP:** Asian Black Hispanic White **MARITAL STATUS:** Single Married Divorced Widowed Separated

FOR DOCTOR USE ONLY: I have reviewed the questionnaire responses. Date: _____ Signature: _____

VERY WELL



VERY POORLY