Arthritis & Osteoporosis ASSOCIATES, LLP

Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D
Theerapol Prasertsuntarasai, M.D. | Autumn Beasley, F.N.P.

Dear _____,

Welcome to the Arthritis & Osteoporosis Associates, L.L.P. family! Our mission is to provide quality and compassionate medical care for patients of the South Plains with rheumatic diseases. As our patient, we put *you* first and realize that our purpose is to improve *your* life. Please do not hesitate to ask any questions regarding procedures, policies, or forms that must be completed for your visit.

An appointment has been scheduled with Dr. Del Giudice for you on

_____, _____ _____ at _____.

Please complete the attached questionnaire and bring it with you on the date of your appointment. Please **DO NOT MAIL** the questionnaire back to us. If you are unable to keep this appointment please contact our office within 24 hours of your appointment time. Broken appointments prevent other patients from receiving timely care. If you fail to keep this appointment you may be billed $75.00.

Please bring all X-Ray, CT, MRI films, labs and progress notes from any physician that pertains to this visit. The doctor will review these films and reports at the time of your visit.

1. All insurance co-pays and deductibles are due at the time of service. This will range from $500 to $1500. This estimate DOES include labs, x-rays, injections performed in our office.
2. All private pay patients will be required to pay in full at the time of service. This will range from $500-$1500. This estimate DOES include labs, x-rays, injections performed in our office.
3. We will not file any non-contracted insurance. Patient is responsible for payment in full at the time of service. Please contact the office if you have any questions regarding your insurance plan. If your insurance plan requires a referral from you Primary Care Physician, you are responsible for obtaining the referral before your appointment. If your referral is not received prior to your appointment, you will be asked to reschedule.
4. **If your care requires lab work and/or x-rays, it is possible that you may receive a separate bill from our lab vendor or x-ray vendor since all tests are not done in our practice.**
5. Please bring someone to interpret if you cannot speak English. If you are a nursing home resident, a family member or nursing home attendant must accompany and stay with you through the duration of the appointment.

Thank you for your cooperation and understanding and for choosing Arthritis & Osteoporosis Associates. We look forward to caring for you.

Signature _____ Date: _____

Arthritis & Osteoporosis ASSOCIATES, LLP

Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D
Theerapol Prasertsuntarasai, M.D. | Autumn Beasley, F.N.P.

To Our Patients:

The physicians of Arthritis & Osteoporosis Associates, Dr. Bushan, Dr. Calmes, Dr. Del Giudice, and Dr. Prasertsuntarasai wish to inform you that they do not attend or consult patients in the hospital. We will, of course, be available to consult by phone with the attending physician and other consultants regarding the hospital care of our patients for continuity of medications and to discuss our patients' rheumatologic diagnosis. One of our physicians will always be on telephone call to advise you regarding problems or emergencies that may arise after hours or on weekends. We do advise each of you to have a personal primary care physician to direct your hospital needs and coordinate appropriate consultations in the hospital.

The face of rheumatology practice is changing nationwide and the trend is for practicing rheumatologists to focus on the outpatient care of our patients. We continue to strive to provide state of the art care of your rheumatic diseases in our outpatient clinic and our time and energies need to be directed toward the care of our office patients. We are adding new technologies in our practice with addition of musculoskeletal ultrasound. We continue to have a very active clinical research department participating in several clinical trials involving new and exciting therapies for the diseases we treat.

As always, we continue to be committed to providing quality care for our patients and are dedicated to making your experience in our outpatient clinic a pleasant experience. We thank you for your loyalty as we partner in your medical care.

Sincerely,

Naga Bushan, M.D.

José Del Giudice

Jose Del Giudice, M.D.

Michael Calmes, M.D.

Theerapol Prasertsuntarasai, M.D.

Please note: This office <u>DOES NOT</u> prescribe Schedule III narcotics including Hyrdocodone
It is the repsonsiblity of the patient to know his/her insurance benefits. Please call your insurance company if you are unsure of your benefit coverage prior to confirming an appointment.

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Patient Information

Last Name: _____ First Name: _____ Middle Initial:_____

Social Security #:_____ Birthdate:_____ AGE:_____ Sex: ☐Male ☐Female

Current Address: _____ State:_____ Zip:_____

Home #:(_____)_____ Work#:(_____)_____ Cell #:(_____)_____

RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: ☐ Self ☐ Spouse ☐ Child ☐Other:_____

Primary Care Physician:_____ Referring Physician:_____

Patient's Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Status: ☐ Employed ☐ Student Employer/School:_____ Phone#:(_____)_____

Spouse's Name: _____ Spouse's Employer:_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT: _____ Phone #:(_____)_____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION:

Last Name: _____ First Name:_____ Middle Initial:_____

Social Security #:_____ Birthdate: _____ Sex: ☐ Male ☐ Female

Permanent Address: _____ State:_____ Zip:_____

Home #:(_____)_____ Cell #:(_____)_____

Employed: ☐ Yes ☐ No Employer:_____ Phone #:(_____)_____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICAL INSURANCE/MEDICARE/MEDICAID INFORMATION:

Type of Medical Insurance: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Workers Comp ☐ Other:_____

Name of Policy Holder: _____ Social Security #:_____

Insurance Company Name:_____ Phone #:(_____)_____

ADDRESS: _____ State:_____ Zip:_____

Identification #:_____ GROUP NAME/#:_____

Medicare #:_____ Medicaid #:_____

Employer Plan? ☐ Yes ☐ No Birthdate:_____ Sex: ☐ Male ☐ Female

Do you have a secondary form of insurance? ☐ Yes ☐ No Company Name:_____

Phone #:(_____)_____ ID#:_____ Group #:_____

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Patient Financial Agreement

PATIENT NAME:_____ **D.O.B.:**_____

Arthritis & Osteoporosis Associated, L.L.P. appreciates the confidence you have shown in choosing us to provide for your medical needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for payment in full. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for the balance in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to *Arthritis & Osteoporosis Associates, L.L.P.* for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of the bill incurred by me or the above name patient; or, if applicable any amount due after payment has been made by my insurance carrier.

PATIENT SIGNATURE:_____ **DATE:**_____

GUARANTOR SIGNATURE:_____ **DATE:**_____

(If guarantor is not the patient)

CO-PAY POLICY

Some health carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time service is rendered for the patient to pay at **EACH VISIT**. Thank you for your cooperation in this matter.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**_____

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap or Medicare Advantage benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these payable for related services.

PATIENT/RESPONSIBLE PARTY SIGNATURE:_____ **DATE:**_____

Patient Financial Agreement (continued)

MEDICAID/PCCM

If the referring physician on my monthly Medicaid card changes, it is my responsibility to obtain the required referral for my appointment with *Arthritis & Osteoporosis Associates, L.L.P.* If I fail to obtain my required referral I understand that my appointment will be rescheduled with no exceptions.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**_____

SELF-PAY

I do not have health insurance and will be responsible for services rendered here at *Arthritis & Osteoporosis Associates, L.L.P.* I agree to pay *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of treatment given to me or to the above named patient at each visit.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**_____

REFERRAL POLICY

As described in my contract with my insurance company, if a referral is required for my visit to an *Arthritis & Osteoporosis Associates, L.L.P.* specialist, I am responsible for obtaining the referral. If I fail to obtain my required referral, I understand that my appointment will be rescheduled with no exceptions.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**_____

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand if I no show for two consecutive ne patient appointments or no show for four follow-up appointments, I will be discharged form medical care.

Arthritis & Osteoporosis Associates, L.L.P. will notify you in writing via certified mail if you are discharged from medical care.

I have read and understood the above information and I agree to the terms described.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**_____

Arthritis & Osteoporosis Associates, LLP.

Consent for Use and Disclosure of Health Information:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

___ Home Telephone: _____
____Leave a detailed message
____ Leave a message with call back number only

___ Written Communication:
___ Mail to home address
___Mail to work/ office address

___Fax to this number: _____

___Work Telephone: _____
___ Leave a detailed message
___Leave a message with call back number only

__ Other: (spouse,child,etc.)
(Please list names of individuals we have consent to speak with regarding your care)

_____

_____

_____

Acknowledgment of Receipt of Notice of Privacy Practices:
You have the right to read our Notice of Policy Practices before you sign this consent. Our notice provides description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available. Which will contain the changes.
AGREEMENT AS TO GOVERNING LAW AND FORUM:
The Patient and healthcare provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any healthcare rendered to patient: and (2) in the event of a dispute any lawsuit, action of cause action which in any way relates to the healthcare provided to patient shall only be brought in a Texas District Court in the county of where all or substantially all of the healthcare was provided or rendered and in no law and forum selection provisions of this paragraph are mandatory and are not permissive.
By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: _____ DATE:_____
(PATIENT OR PERSONAL REPRESENTATIVE)

PRINT NAME: _____

RELATIONSHIP TO PATIENT (if signed by personal representative):_____

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Patient Questionnaire

Date of Appointment: ____/____/____ Time of Appointment: _____ Birthplace: _____

Name: _____ Birthdate: _____

Last First Middle Initial Malden

Address: _____ Age: _____ Sex: ☐M ☐F

Street Apt #

_____ Telephone: Home _____

City State Zip Work _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Cell _____

Spouse/Significant Other: ☐Alive/Age ____ ☐Deceased/Age ____ ☐Major Illness _____

Education (circle highest level attended):

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

Occupation: _____ Average hours worked per week: _____

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

Name of person making referral: _____

Name of person 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): ____/____/____

Diagnosis given (please list): _____

_____

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: _____

_____

Rheumatologic (Arthritis) History

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

Diagnosis	Yourself	Relative Name	Relationship
Arthritis (unknown type)			
Osteoarthritis			
Gout			
Childhood Arthritis			
Lupus or SLE			
Rheumatoid Arthritis			
Ankylosing Spondylitis			
Osteoporosis			
Other arthritis condtions:			

Date_____ Initials _____

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Systems Review

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

Date of last mammogram:___/___/___ Date of last eye exam:___/___/___ Date of last chest X-ray:___/___/___

Date of last TB test: ___/___/___ Date of last bone densitometry:___/___/___

Constitutional

☐Recent weight gain/amount:_____
☐Recent weight loss/amount:_____
☐Fatigue
☐Weakness
☐Fever

Eyes

☐Pain
☐Redness
☐Loss of vision
☐Double or blurred vision
☐Dryness
☐Feels like something in eyes
☐Itching eyes

Ears/Nose/Mouth/Throat

☐Ringing in ears
☐Loss of hearing
☐Nosebleeds
☐Loss of smell
☐Dryness in nose
☐Runny nose
☐Sore tongue
☐Bleeding gums
☐Sores in mouth
☐Loss of taste
☐Dryness of mouth
☐Frequent sore throats
☐Hoarseness
☐Difficulty swallowing

Cardiovascular

☐Pain in chest
☐Irregular heart beat
☐Sudden changes is heart beat
☐High blood pressure
☐Heart murmurs

Respiratory

☐Shortness of breath
☐Difficulty in breathing at night
☐Swollen legs or feet
☐Cough
☐Coughing of blood
☐Wheezing (asthma)

Gastrointestinal

☐Nausea
☐Vomiting of blood
☐Stomach pain relieved with food
☐Jaundice
☐Increasing constipation
☐Persistent diarrhea
☐Blood in stools
☐Black stools
☐Heartburn

Genitourinary

☐Difficult urination
☐Pain or burning on urination
☐Blood in urine
☐Cloudy, "smoky" urine
☐Pus in urine
☐Discharge from penis/vagina
☐Getting up at night to urinate
☐Vaginal dryness
☐Rash/ulcers
☐Sexual difficulties
☐Prostate trouble

For women only

Age when periods began:_____
Periods regular? ☐Yes ☐No
How many days apart?_____
Date of last period:___/___/___
Date of last pap: ___/___/___
Bleeding after menopause?
☐Yes ☐No
Number of pregnancies:_____
Number of miscarriages:_____

Musculoskeletal

☐Morning stiffness
Lasting how long?___min___hrs
☐Joint pain
☐Muscle weakness
☐Muscle tenderness
☐Joint swelling
List joints affected in the last 6 mo.

_____
_____
_____
_____

Integumentary

☐Easy bruising
☐Redness
☐Rash
☐Hives
☐Sun sensitive (sun allergy)
☐Tightness
☐Nodules/bumps
☐Hair loss
☐Color changes of hands or feet in the cold

Neurological System

☐Headaches
☐Dizziness
☐Fainting
☐Muscle spasm
☐Loss of consciousness
☐Sensitivity or pain of hands and/or feet
☐Memory loss
☐Night sweats

Psychiatric

☐Excessive worries
☐Anxiety
☐Easily losing temper
☐Depression
☐Agitation
☐Difficulty falling asleep
☐Difficulty staying asleep

Endocrine

☐Excessive thirst

Hematologic/Lymphatic

☐Swollen glands
☐Tender glands
☐Anemia
☐Bleeding tendency
☐Blood transfusion/when?_____

Allergic/Immunologic

☐Frequent sneezing
☐Increased susceptibility to infection

Date_____ Initials_____

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Patient History Form

SOCIAL HISTORY

Do you drink caffeinated beverages? ☐Yes ☐No

Cup/glasses per day:_____

Do you smoke? ☐Yes ☐No ☐Past How long?_____

Do you drink alcohol? ☐Yes ☐No # per week?_____

Has anyone ever told you to cut down on your drinking?
☐Yes ☐No

Do you use drugs for reasons that are not medical?
☐Yes ☐No If yes please list:_____

_____

Do you exercise regularly? ☐Yes ☐No

Type:_____

Amount per week:_____

How many hours of sleep do you get at night?_____

Do you get enough sleep at night? ☐Yes ☐No

Do you wake up feeling rested? ☐Yes ☐No

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if yes)

☐ Cancer	☐ Heart problems	☐ Asthma
☐ Goiter	☐ Leukemia	☐ Stroke
☐ Cataracts	☐ Diabetes	☐ Epilepsy
☐ Nervous breakdown	☐ High blood pressure	☐ Rheumatic fever
☐ Headaches	☐ Jaundice	☐ Colitis
☐ Kidney disease	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ Stomach ulcers	☐ HIV/AIDS
☐ Emphysema	☐ Glaucoma	☐ Tuberculosis

Other significant illness (please list):_____

_____

_____

Previous operations:

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

Any previous fractures? ☐Yes ☐No Describe:_____

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

Family History:

		If Living		If Deceased
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings:_____ Number of living:_____ Number or deceased:_____

Number of children:_____ Number of living:_____ Number of deceased:_____ List ages of each:_____

Health of children:_____

Do you know of any blood relative 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_____ ☐Osteoporosis_____

Are you receiving disability? ☐Yes ☐No Are you applying for disability? ☐Yes ☐No

Do you have a medically related lawsuit pending? ☐Yes ☐No

Date:_____ Initials:_____

Arthritis & Osteoporosis Associates, L.L.P.
Jose Del Giudice, M.D.

Medications

Drug allergies: ☐ Yes ☐ No to what?_____

_____

Type of reaction:_____

Current medications (list any medications you are currently taking including over-the-counter medications)

Name of drug	Dose (include strength & # of pills per day)	How long have you taken this medication?	Helped A lot	Helped Some	Helped Not at all

Past Medications: Pleas review this list of 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.

Drug Names	Length of time	Has this helped? A lot	Some	Not at all	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)					
Ansaid (flurbiprofen)					
Daypro (oxaprozin)					
Meclomen (meclofenamate)					
Tolectin (tolmetin)					
Voltaren (diclofenac)					
Arthrotec (diclofenac + misorostil)					
Disalcid (salsalate)					
Motrin (ibuprofen)					
Trilisate (choline magnesium trisalicylate)					
Clinoril (sulindac)					
Aspirin					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Nalfon (fenoprofen)					
Lodine (etodolac)					
Vioxx (rofecoxib)					
Celebrex (celecoxib)					
Indocin (indomethacin)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Mobic (meloxicam)					
Relafen (nabumetone)					
Pain Relievers					
Tylenol (acetaminophen)					
Codeine (Tylenol #3)					
Norco, Lortab (hydrocodone)					
Ultram, Ultracet (tramadol)					

Date:_____ Initials:_____

Medications (continued)

Disease Modifying Antirheumatic Drugs (DMARDS) or Immunosuppressive Drugs:

Auranofin (ridaura-gold pills)					
Myochrysine (gold shots)					
Plaquenil (hydroxychloroquine)					
Cuprimine/Depen (peniciflamine)					
Rheumatrex (methotrexate)					
Arava (leflunomide)					
Imuran (azathioprine)					
Azulfidine (sulfasalazine)					
Atabrine (quinacrine)					
Cytoxan (cyclophosphamide)					
Sandimmune/Neora (cyclosporine)					
Enbrel (etanercept)					
Humira (adalimumab)					
Simponi (golimumab)					
Cimzia (certolizumab)					
Remicade (infliximab)					
Orencia (abatacept)					
Actemra (tocilizumab)					
Benlysta (belimumab)					
Prosorba Colunm					

Osteoporosis Medications:

Premarin (estrogen)					
Fosamax (alendronate)					
Actonel (residronate)					
Didronel (etidronate)					
Evista (raloxifene)					
Fluoride					
Miacalcin (calcitonin injections)					
Boniva (ibandronate)					
Prolia (denosumab)					
Reclast (zoledronic acid)					
Forteo (teriparatide)					

Gout Medications:

Benemid (probenecid)					
Colcrys (colchicine)					
Zyloprim/Lopurin (allopurinol)					
Uloric (febuxostat)					
Krystexxa (pegloticase)					

Others:

Prednisone (cortisone)					
Hyalgan/Synvisc/Supartz					

Have you participated in any clinical trials foe new medications? ☐Yes ☐No

If yes, list: _____

_____

Date:_____Initials:_____

Clinical Health Assessment Questionnaire

Name _____ Date _____

We are interested in learning how your illness affects your ability to function in daily life.

Please check the response which best describes your usual abilities over the past week.

	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable to Do
Dressing & Grooming				
Are you able to:				
Dress yourself, including shoelaces and buttons?	_____	_____	_____	_____
Shampoo your hair?	_____	_____	_____	_____
Arising				
Are you able to:				
Stand up from a straight chair?	_____	_____	_____	_____
Get in and out of bed?	_____	_____	_____	_____
Eating				
Are you able to:				
Cut your meat?	_____	_____	_____	_____
Lift a full cup or glass to your mouth?	_____	_____	_____	_____
Open a new milk carton?				
Walking				
Are you able to:				
Walk outdoors on flat ground?	_____	_____	_____	_____
Climb up five steps?	_____	_____	_____	_____

Please check any aids or devices that you usually use for any of these activities:

_____ Cane _____ Walker _____ Built up or special utensils

_____ Crutches _____ Wheelchair _____ Special or built up chair

_____ Devices used for dressing (button hook, zipper pull, long handled shoe horn)

_____ Other, specify: _____

Please check any categories for which you usually need help from another person:

_____ Dressing and grooming _____ Eating

_____ Arising _____ Walking

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness in the past week?

Place a mark on the line to indicate the severity of the pain

No Pain — Severe Pain

_____

We are also interested in learning about the severity of your illness.

Consider all the ways that your illness affects you, rate how you are doing on the following scale by placing a mark on the line

Very Well — Very Poorly

_____

For Internal Use Only

Dressing _____ (184)

Arising _____ (175)

Eating _____ (183)

Walking _____ (174)

Painscale _____ (453)

Global _____ (156)

Clinical Health Assessment Questionnaire (continued)

Please check the response which best describes your usual abilities over the past week:

	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable to Do
Hygiene				
Are you able to:				
Wash and dry your body?	_____	_____	_____	_____
Take a tub bath?	_____	_____	_____	_____
Get on and off the toilet?	_____	_____	_____	_____
Reach				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	_____	_____	_____	_____
Bend down to pick up clothing from the floor?	_____	_____	_____	_____
Grip				
Are you able to:				
Open car doors?	_____	_____	_____	_____
Open jars which have been previously opened?	_____	_____	_____	_____
Turn faucets on and off?	_____	_____	_____	_____
Activities				
Are you able to:				
Run errancds and shop?	_____	_____	_____	_____
Get in and out of a car?	_____	_____	_____	_____
Dor chores such as vacuuming or yard work?	_____	_____	_____	_____

For Internal Use Only

Hygiene ____ (185)

Reach ____ (172)

Grip ____ (584)

Activity ____ (583)

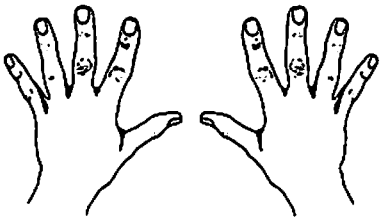
Please check any aids or devices that you usually use for any of these activities:

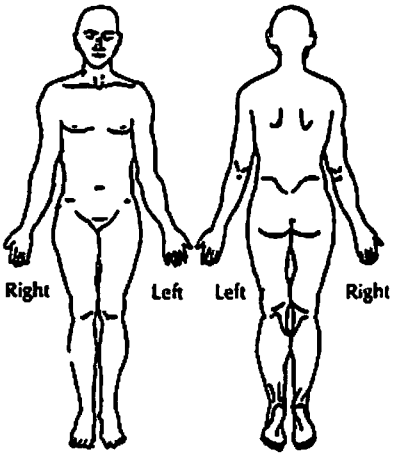
_____ Bathtub
_____ Raised toilet seat
_____ Long-handled appliances for reach
_____ Long-handled appliances in bathroom
_____ Jar opener for jars previously opened
_____ Other, specify: _____

Please check any categories for which you usually need help form another person:

_____ Hygiene
_____ Reach
_____ Gripping and opening things
_____ Errands and chores

Please indicate all the locations of your pain over the past week by shading the body figures and hands below:

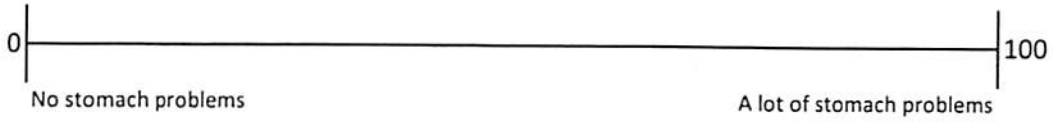




Clinical Health Assessment Questionnaire

(Continued)

How much trouble have you had with your stomach (nausea, heartburn, bloating, pain, etc.) in the past week? Please mark on the line below.



How much of a problem has sleep (resting at night) been for you in the past week? Please mark on the line below.

In general, would you say your health now is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

During the last 6 months, if you were:

1.) Employed: ☐ Yes ☐ No Occupation: _____

OR

2.) A housewife or househusband, please answer the next four questions.

	All Days 100%	Most Days 70-99%	Some Days 41-69%	Few Days 1-40%	No Days 0%
How often were you able to work?	____	____	____	____	____
How often did you have to work a shorter day?	____	____	____	____	____
How often were you able to do your work as carefully and accurately as you would like?	____	____	____	____	____
How often did you have to change the way your work was usually done?	____	____	____	____	____

How satisfied are you with your health now?

☐ Very Satisfied ☐ Somewhat Satisfied

☐ Neither satisfied nor dissatisfied

☐ Very Dissatisfied ☐ Somewhat Dissatisfied

	HAQ	AIMS
0	0.000	
1	0.125	
2	0.250	
3	0.375	
4	0.500	
5	0.625	
6	0.750	0.00
7	0.875	0.33
8	1.000	0.66
9	1.125	0.99
10	1.375	1.32
11	1.500	1.65
12	1.625	1.98
13	1.750	2.31
14	1.875	2.64
15	2.000	2.97
16	2.125	3.30
17	2.125	3.63
18	2.250	3.96
19	2.375	4.29
20	2.500	4.62
21	2.625	4.95
22	2.750	5.28
23	2.875	5.61
24	3.000	5.94
25		6.27
26		6.60
27		6.93
28		7.26
29		7.59
30		7.92
31		8.25
32		8.58
33		8.91
34		9.24
35		9.57
36		9.90

Ablewk _____

Shortwk _____

Accuwk _____

Chngwk _____

Clinical Health Assessment Questionnaire

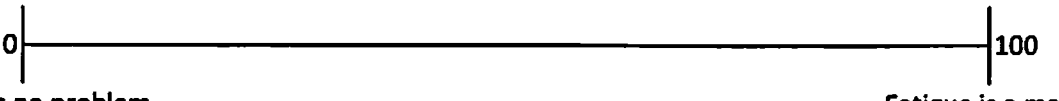
(Continued)

Please check the most appropriate answer for each question.
Try to answer every question.

	Always	Very Often	Fairly Often	Some Times	Almost Never	Never
1. During the PAST MONTH, how much of the time have you enjoyed the things you do?						
2. During the PAST MONTH, how much of the time have you felt tense or "high strung"?						
3. How much have you been bothered by nervousness, or your "nerves" during the PAST MONTH?						
4. How often during the PAST MONTH, did you find yourself having difficulty trying to calm down?						
5. During the PAST MONTH, how much of the time have you been in low or very low spirits?						
6. How much of the time during the PAST MONTH did you feel relaxed and free of tension?						
7. How much of the time during the PAST MONTH have you felt downhearted and blue?						
8. How often during the PAST MONTH did you feel that nothing turned out for you the way you wanted it to?						
9. How much of the time during the PAST MONTH have you felt calm and peaceful?						
10. During the PAST MONTH, how often did you feel that others would be better off if you were dead?						
11. How much of the time during the PAST MONTH were you able to relax without difficulty?						
12. How often during the PAST MONTH have you felt so down in the dumps that nothing could cheer you up?						

We are interested in konwing about any problems that you may have been having with fatigue.
How much of a problem has fatigue or tirednes been for you in the past month?

Place a mark on the line below.



Fatigue is no problem

Fatigue is a major problem