Arthritis & Osteoporosis
ASSOCIATES, LLP

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 _____for you on

_____, _____ _____ at _____. (5220 80th St Lubbock TX)

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 more than 24 hours before your appointment time. **If you fail to keep this N*ew Patient* appointment, you will be billed $250.00. Also, if you fail to keep your N*ew Patient Follow Up* appointment, you will be billed $125 to reschedule.**

Please bring all X-Ray, CT, MRI films, labs and progress notes from any physician that pertains to this visit. The provider 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 can range from $300 to $600. This estimate DOES include labs, x-rays, and injections performed in our office.

2. All private pay patients will be required to pay in full at the time of service. This can range from $300 to $600. This estimate DOES include labs, x-rays, and injections performed in our office.

3. We will not file any non-contracted insurance. Please contact the office if you have any questions regarding your insurance plan. If your insurance plan requires a referral from your 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, it is possible that you may receive a separate bill from our lab vendor (Quest) since all lab tests are not done in our practice.

5. If you require an interpreter, please bring one with you. 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: _____

NEW PATIENT CHECKLIST

IF NEED TO RESCHEDULE:

*___ Please note that **ALL clinic visits must be cancelled at least 24 hours prior** to the visit to avoid incurring "no-show" fees.*

*This is to help cut down wait times and allow us to schedule patients on waiting lists. Please note that "no-showing" a new patient visit will result in a **$250 fee** which must be paid prior to rescheduling.*

We thank you for your cooperation so that we can make your appointment day as smooth as possible! We look forward to meeting you and delivering the best healthcare possible.

To help expedite your care and avoid any possible delays, we kindly ask that you make sure to complete the following checklist and bring all items requested below.

PLEASE BRING:

*__ **COMPLETED New Patient Packet***

Please confirm your new patient packet is completed BEFORE you arrive for your appointment. This form is quite lengthy and arriving at your appointment without it completed will unfortunately result in RESCHEDULING your visit.

*___ **ALL insurance cards**, including any supplemental or secondary plans.*

Please note it is your responsibility to confirm required insurance referrals are up to date for your initial and any follow-up appointments. If referrals are not current, you will be rescheduled or billed as a "self-pay" patient if desired.

*___ **An up-to-date list or the bottles of ALL medications** you are taking.*

Please include any over the counter supplements

*___ **Payment for your services***

***Payments are due on the day of service.** Below is an estimate of your cost based on your insurance benefits.*

OFFICE VISIT: _____ LAB: _____ IMAGE/XRAY: _____

THINGS TO KNOW:

*___ **Fasting is NOT required**. Please feel free to eat before your appointment.*

*___ **New patient visits can take up to 2 hours.***

This includes your check in time, visit, and any lab or imaging that will be done. Please plan accordingly so that your visit is not cut short.

Welcome to Arthritis & Osteoporosis Associates, LLP.
We thank you for your cooperation so that we can make your appointment day as smooth as possible.

Arthritis & Osteoporosis

ASSOCIATES, LLP

To Our Patients:

The physicians of Arthritis & Osteoporosis Associates (Dr. Bushan, Dr. Calmes, and Dr. Warmoth) along with our mid-level practitioners (Ravyn Barr, Autumn Beasley, Misty Fortner and Lynsey Rather) wish to inform you that they do not attend nor consult patients in the hospital. We will, of course, be available to consult by telephone 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. 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. Also, we do not take after-hours or weekend calls.

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 for your rheumatic diseases in our outpatient clinic and our time and energy need to be directed toward the care of our office patients.

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.

J. Michael Calmes, M.D.

Taylor Warmoth, M.D.

Ravyn Barr, F.N.P.

Autumn Beasley, F.N.P.

Misty Fortner, P.A.

Lynsey Rather, F.N.P.

Please note: This office DOES NOT prescribe Schedule III narcotics including Hydrocodone.

Our mid-level practitioners are an integral part of your care team. Please note that appointments will be scheduled with them as determined by your physician.

The office DOES NOT complete disability paperwork.

It is the responsibility 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.

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.

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 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 / DEDUCTIBLE POLICY

Some health carriers require the patient to pay a co-pay and/or deductible for services rendered. You will be responsible for any co-pay and/or deductibles required for each visit.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made 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 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 exception.

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. If you fail to cancel your appointment within 24 hours, you will be charged $75.00.

I understand if I no show for two consecutive patient appointments or no show for four follow-up appointments, I will be discharged from the practice.

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

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

PATIENT/GUARANTOR SIGNATURE:_____DATE:_____

Arthritis & Osteoporosis Associates, L.L.P.

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
- ☐ Work telephone:_____
  - ☐ Leave a detailed message
  - ☐ Leave a message with call back number only
- ☐ Written Communication
  - ☐ Mail to home address
  - ☐ Mail to work/office address
- ☐ Other (spouse, child, etc.)
  Please list names of individuals we have consent to speak with regarding your care.
  _____
  _____
  _____
- ☐ Fax to this number:_____

Acknowledgement 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 a 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 or 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 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): _____

Patient History Form (Rheumatology)

Date of appointment:_____/_____/_____ Time of appointment:_____ Birth Place:_____

Last name:_____ First name:_____ MI:_____ DOB:_____/_____/_____

Address:_____ City:_____ State:_____ Age:_____ Sex: ☐ Male ☐ Female

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

Marital Status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

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:_____ Number of hours worked/average per week:_____

Referred by: ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other health profession

Name of person making referral:_____ Primary Care Physician:_____

Do you have an orthopedic surgeon? __Yes __ No If yes, name_____

Describe briefly your present symptoms:_____

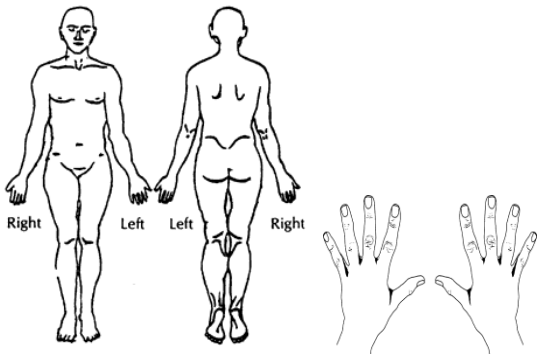
_____

Date symptoms began: ___/___/___

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

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

Please shade all the locations of our pain over the past week on the body and hands:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

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

Yourself		Relative/Relation	Yourself		Relative/Relation
	Arthritis (unknown type)			Lupus or SLE	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	

Other arthritis conditions:_____

Date:_____ Initials:_____

Patient History Form (continued)

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.

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.

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)					
Ansald (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)					
Rheumatrex (methotrexate)					
Arava (leflunomide)					
Imuran (azathioprine)					
Azulfidine (sulfasalazine)					
Atabrine (quinacrine)					
Cytoxan (cyclophosphamide)					
Sandimmune (cyclosporine)					
Enbrel (etanercept)					
Humira (adalimumab)					
Simponi (golimumab)					
Cimzia (certolizumab)					
Remicade (inflixlmab)					
Orencia (abatacept)					
Actemra (tocilizumab)					
Benlysta (belimumab)					
Prosorba Column					
Xeljanz, Rinvoq					
Skyrizi, Bimzelx					

Osteoporosis Medications:

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

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 for new medications? ☐Yes ☐No

If yes, list: _____

_____

Date:_____Initials:_____

Patient Name: _____Date of Birth:_____Date:_____/_____/_____

ARTHRITIS AND OSTEOPOROSIS ASSOCIATES RAPID 3 ASSESSMENT QUESTIONNAIRE

PLEASE CHECK ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:
There are no wrong answers.

Over the last WEEK, were you able to:	***Without ANY Difficulty***	***SOME Difficulty***	***MUCH Difficulty***	***UNABLE to do***
Dress yourself, tie shoelaces, and use buttons?	__ 0	__ 1	__ 2	__ 3
Get in and out of bed?	__ 0	__ 1	__ 2	__ 3
Lift a full cup or glass to your mouth?	__ 0	__ 1	__ 2	__ 3
Walk outdoors on flat ground?	__ 0	__ 1	__ 2	__ 3
Wash and dry your entire body?	__ 0	__ 1	__ 2	__ 3
Bend down to pick up clothing from the floor?	__ 0	__ 1	__ 2	__ 3
Turn regular faucets on and off?	__ 0	__ 1	__ 2	__ 3
Get in and out of a car, bus, train, or airplane?	__ 0	__ 1	__ 2	__ 3
Walk two miles (or three kilometers), if you wish?	__ 0	__ 1	__ 2	__ 3
Participate in recreational activities/sports as desired?	__ 0	__ 1	__ 2	__ 3
Get a good night's sleep?	__ 0	__ 1	__ 2	__ 3
Deal with feelings of anxiety or being nervous?	__ 0	__ 1	__ 2	__ 3
Deal with feelings of depression or feeling blue?	__ 0	__ 1	__ 2	__ 3

How much pain have you had because of your condition over the past week? (circle one)

No pain																			Pain as bad as it can be
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10

Considering all the ways in which illness and health conditions may affect you at this time, how are you doing? (circle one)

Very well																			Very poorly
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10

Office use only: Score: 1. FN_____ 2, PN_____ 3, PTGE_____ RAPID3_____