Refillable

Health Log

_____
*Health log belongs to*

_____
date

1. In general, would you say your health is?

❏ Excellent ❏ Very good ❏ Good ❏ Fair ❏ Poor

2. Does your health now limit you in the following activities:
And if so, how much?

a. Moderate activities, such as moving a table, pushing
your vacuum cleaner, bowling or playing golf.

❏ Yes limited a lot ❏ Limited a little ❏ Not limited at all

b. Climbing several flights of stairs.

❏ Yes limited a lot ❏ Limited a little ❏ Not limited at all

3. During the past four weeks, have you accomplished less than
you would like as a result of your physical health?

❏ Yes   ❏ No

4. During the past four weeks, were you limited in the kind of
work or other regular activities you do as a result of your
physical health?

❏ Yes   ❏ No

5. During the past four weeks, have you accomplished less than
you would like to as a result of any emotional problems,
such as feeling depressed or anxious?

❏ Yes   ❏ No

6. During the past four weeks, did you not do work or other
regular activities as carefully as usual as a result of any
emotional problems such as feeling depressed or anxious?

❏ Yes   ❏ No

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling.

7. During the past *4 weeks* much did pain interfere with your normal work, including both work outside the home and housework?

❏ Not at all ❏ A little bit ❏ Moderately ❏ Quite a bit ❏ Extremely

8. How much of the time during the past *4 weeks* have you felt calm and peaceful?

❏ All of the time ❏ Most of the time ❏ Some of the time
❏ A little of the time ❏ None of the time

9. How much of the time during the past *4 weeks* did you have a lot of energy?

❏ All of the time ❏ Most of the time ❏ Some of the time
❏ A little of the time ❏ None of the time

10. How much time during the past *4 weeks* have you felt down?

❏ All of the time ❏ Most of the time ❏ Some of the time
❏ A little of the time ❏ None of the time

11. During the past *4 weeks*, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends, relatives, etc?

❏ All of the time ❏ Most of the time ❏ Some of the time
❏ A little of the time ❏ None of the time

Over the past week:

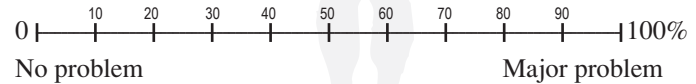How much pain have you had because of your illness?

0 |—10—20—30—40—50—60—70—80—90—| 100%
No pain   Severe pain
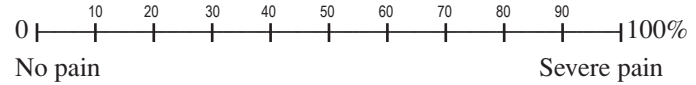
How much of a problem has fatigue or tiredness been for you in the past week?

0 |—10—20—30—40—50—60—70—80—90—| 100%
No problem   Major problem

Considering all the ways that your illness affects you, rate how you are doing on the following scale:

0 |—10—20—30—40—50—60—70—80—90—| 100%
Very well   Very poorly

How much of a problem has morning stiffness been?

0 |—10—20—30—40—50—60—70—80—90—| 100%
No problem   Major problem

Have your thoughts been more positive or negative? _____
_____

Has your mood been more positive or negative? _____
_____

We are interested in learning how your illness affects your ability to function in daily life. Please mark with a ✓ the response which best describes your usual abilities **OVER THE PAST WEEK**: (please answer each line a – i)

	Without any difficulty	With some difficulty	With much difficulty	Unable to do
a. Dress yourself, including shoelaces and buttons?				
b. Get in and out of bed?				
c. Lift a full cup or glass to your mouth?				
d. Walk outdoors on flat ground?				
e. Wash and dry your entire body?				
f. Bend down to pick up clothing from the floor?				
g. Turn faucets on and off?				
h. Get in and out of a car, bus, train, or airplane?				
i. Walk two miles?				

1. ARTHRITIC PAIN AND JOINT EVALUATION

(RA DISEASE ACTIVITY INDEX)

Please indicate the amount of pain you are having **TODAY** in **EACH** of the joint areas illustrated below. <u>Please fill in the response next to "None" if you do not have pain in the indicated joint.</u>

1. Right Shoulder
○ Painful
○ Not Painful

2. Left Shoulder
○ Painful
○ Not Painful

3. Right Elbow
○ Painful
○ Not Painful

4. Left Elbow
○ Painful
○ Not Painful

5. Right Hip
○ Painful
○ Not Painful

6. Left Hip
○ Painful
○ Not Painful

7. Right Wrist
○ Painful
○ Not Painful

8. Left Wrist
○ Painful
○ Not Painful

9. Right Hand Fingers
○ Painful
○ Not Painful

10. Left Hand Fingers
○ Painful
○ Not Painful

11. Right Knee
○ Painful
○ Not Painful

12. Left Knee
○ Painful
○ Not Painful

13. Right Ankle
○ Painful
○ Not Painful

14. Left Ankle
○ Painful
○ Not Painful

15. Right Foot Toes
○ Painful
○ Not Painful

16. Left Foot Toes
○ Painful
○ Not Painful

6.

My goals for today's visit are:

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My questions for today's visit are:

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7.

Notes

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PRESCRIPTION REFILLS NEEDED

Medication Name	Dosage

Notes

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