

**ARTHRITIS & OSTEOPOROSIS ASSOCIATES OF NEW MEXICO**

**Art Snyder, M.D., / Gregory Maroney, PA-C**

**Rheumatology**

**1255 Hillrise Cr., Las Cruces, NM. 88011**

**Phone (505) 532-5934 \* Fax (505) 522-9047**

**\* www.arthritisnm.com \***

You are scheduled for an appointment on \_\_\_\_\_ at \_\_\_\_\_ . Please be sure to check-in with the front office personnel when you arrive for your scheduled appointment. We strive in giving prompt and efficient service for each patient and their care.

You have an appointment for a rheumatology consultation. Please complete this medical history questionnaire **BEFORE** your appointment. This information is essential in completing a thorough evaluation and care.

It is necessary to have a primary care physician to whom the doctor will send your consultation report and who will provide long-term follow up care. The doctor is available during clinic hours. If you have any questions or concerns please call our office. Please contact your primary care physician after hours, holidays and weekends.

**Please plan on being in the office for a lengthy initial visit (approx: 2 to 3hrs.) as we do all diagnostic studies in our facility to provide a thorough examination and diagnosis.**

**Please be here 15-20 minutes early and bring any recent labs, x-rays, MRI's, bone scans (reports only are sufficient), all medications and supplements you are taking and doctor's referral.**

**Please be informed that we do not accept any *Presbyterian and United Healthcare Plans.***

Thank you,

Arthur Snyder, M.D.

Gregory Maroney, PA-C

ART SNYDER MD,  
GREGORY MARONEY PA-C

PLEASE PRINT

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ SS# \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ GENDER \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ CELL/WORK: \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY? NEAREST FRIEND  
OR RELATIVE NOT LIVING WITH YOU. (REQUIRED)

NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_

WHO IS THE REFERRING DOCTOR? \_\_\_\_\_  
WHO IS YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_ MARRIED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_

SPOUSES NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
SS#: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAY MEDICAL INFORMATION BE RELEASED TO SPOUSE OR FAMILY  
MEMBERS?

NAME OF INSURANCE CO: \_\_\_\_\_  
POLICY # \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT.  
NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERS  
PAYMENTS; HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, INSURANCE  
AUTHORIZATIONS AND ASSIGNMENTS.

I HEREBY AUTHORIZE DR. SNYDER TO FURNISH INFORMATION TO MY INSURANCE  
CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND ASSIGN TO THE  
PHYSICIAN ALL PAYMENTS OR MEDICAL SERVICES RENDERED FOR MYSELF OR MY  
DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT  
COVERED BY MY INSURANCE CARRIER. I HEREBY CONSENT TO BE EXAMINED BY DR.  
SNYDER IN ORDER TO EVALUATE MY CONDITION AND PROVIDE ME WITH A  
DIAGNOSIS AND TREATMENT AS NECESSARY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PROTECTED HEALTH INFORMATION  
DISCLOSURE RECORD**

Patient Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**Authorized Methods of Communication  
(Check all that Apply)**

**AUTHORIZED PERSONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Residence Telephone**

Number: \_\_\_\_\_

- Leave call back number only; do not leave message
- Okay to leave detailed message with person
- Okay to leave detailed message on answering machine

**Cellular Phone**

Number: \_\_\_\_\_

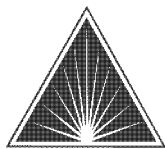
- Leave call back number only; do not leave message
- Okay to leave detailed message on personal voice mail

**Work Telephone**

Number: \_\_\_\_\_

- Leave call back number only; do not leave message
- Okay to leave detailed message with operator
- Okay to leave detailed message on personal voice mail

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# AMERICAN COLLEGE OF RHEUMATOLOGY

EDUCATION • TREATMENT • RESEARCH

## Patient History Form

Date of first appointment: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time of appointment: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
MONTH DAY YEAR

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
STREET APT#

\_\_\_\_\_  
CITY STATE ZIP Telephone: Home (\_\_\_\_\_) Work (\_\_\_\_\_)

**MARITAL STATUS:**  Never Married  Married  Divorced  Separated  Widowed

Spouse/Significant Other:  Alive/Age \_\_\_\_\_  Deceased/Age \_\_\_\_\_ Major Illnesses \_\_\_\_\_

**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 here by: (check one)  Self  Family  Friend  Doctor  Other Health Professional

Name of person making referral: \_\_\_\_\_

The name of the physician 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): \_\_\_\_\_ **Example**

Diagnosis: \_\_\_\_\_

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:

\_\_\_\_\_  
 \_\_\_\_\_

Please shade all the locations of your pain **over the past week** on the **body figures and hands**.

Example:

Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9):1797-808. Used by permission.

**RHEUMATOLOGIC (ARTHRITIS) HISTORY**

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

Yourself	Relative Name/Relationship	Yourself	Relative Name/Relationship
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: \_\_\_\_\_

SYSTEMS REVIEW

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

Date of last mammogram \_\_\_/\_\_\_/\_\_\_ Date of last eye exam \_\_\_/\_\_\_/\_\_\_ Date of last chest x-ray \_\_\_/\_\_\_/\_\_\_
Date of last Tuberculosis 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 eye
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 in swallowing

Cardiovascular

- Pain in chest
Irregular heart beat
Sudden changes in 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 or coffee ground material
Stomach pain relieved by food or milk
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 pass urine
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? Minutes Hours
Joint pain
Muscle weakness
Muscle tenderness
Joint swelling

List joints affected in the last 6 mos.

Blank lines for listing affected joints.

Integumentary (skin and/or breast)

- 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
Transfusion/when

Allergic/Immunologic

- Frequent sneezing
Increased susceptibility to infection

Patient's Name Date Physician Initials

**SOCIAL HISTORY**

Do you drink caffeinated beverages?  
 Cups/glasses per day? \_\_\_\_\_

Do you smoke?  Yes  No  Past – How long ago? \_\_\_\_\_

Do you drink alcohol?  Yes  No Number 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")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bad headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list) \_\_\_\_\_

\_\_\_\_\_

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Previous Operations**

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

Any previous fractures?  No  Yes Describe: \_\_\_\_\_

Any other serious injuries?  No  Yes Describe: \_\_\_\_\_

**FAMILY HISTORY:**

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_

Number of children \_\_\_\_\_ Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ List ages of each \_\_\_\_\_

Health of children: \_\_\_\_\_

Do you know of any blood relative who has or had: (check and give relationship)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Heart disease _____       | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Epilepsy _____        | <input type="checkbox"/> Diabetes _____     |
| <input type="checkbox"/> Stroke _____   | <input type="checkbox"/> Bleeding tendency _____   | <input type="checkbox"/> Asthma _____          | <input type="checkbox"/> Goiter _____       |
| <input type="checkbox"/> Colitis _____  | <input type="checkbox"/> Alcoholism _____          | <input type="checkbox"/> Psoriasis _____       |   |

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_

Patient History Form © 1999 American College of Rheumatology

**MEDICATIONS**

Drug allergies:     No         Yes        To what? \_\_\_\_\_

Type of reaction: \_\_\_\_\_

**PRESENT MEDICATIONS** (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped?		
			A Lot	Some	Not At All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PAST MEDICATIONS** Please review this list of "arthritis" 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. Record your comments in the spaces provided.

Drug names/Dosage	Length of time	Please check: Helped?			Reactions
		A Lot	Some	Not At All	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Circle any you have taken in the past</b>					
Ansaïd (flurbiprofen)    Arthrotec (diclofenac + misoprostil)    Aspirin (including coated aspirin)    Celebrex (celecoxib)    Clinoril (sulindac)					
Daypro (oxaprozin)    Disalcid (salsalate)    Dolobid (diflunisal)    Feldene (piroxicam)    Indocin (indomethacin)    Lodine (etodolac)					
Meclomen (meclofenamate)    Motrin/Rufen (ibuprofen)    Nalfon (fenoprofen)    Naprosyn (naproxen)    Oruvail (ketoprofen)					
Tolectin (tolmetin)    Trilisate (choline magnesium trisalicylate)    Vioxx (rofecoxib)    Voltaren (diclofenac)					
<b>Pain Relievers</b>					
Acetaminophen (Tylenol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Codeine (Vicodin, Tylenol 3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene (Darvon/Darvocet)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Disease Modifying Antirheumatic Drugs (DMARDs)</b>					
Auranofin, gold pills (Ridaura)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gold shots (Myochrysine or Solganol)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hydroxychloroquine (Plaquenil)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillamine (Cuprimine or Depen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methotrexate (Rheumatrex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Azathioprine (Imuran)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfasalazine (Azulfidine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quinacrine (Atabrine)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cyclosporine A (Sandimmune or Neoral)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etanercept (Enbrel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infliximab (Remicade)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prosorba Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Physician Initials \_\_\_\_\_  
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**PAST MEDICATIONS Continued**

<b>Osteoporosis Medications</b>					
Estrogen (Premarin, etc.)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alendronate (Fosamax)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etidronate (Didronel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Raloxifene (Evista)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluoride		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Calcitonin injection or nasal (Miacalcin, Calcimar)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Risedronate (Actonel)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gout Medications</b>					
Probenecid (Benemid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colchicine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allopurinol (Zyloprim/Lopurin)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Others</b>					
Tamoxifen (Nolvadex)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tiludronate (Skelid)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone/Prednisone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyalgan/Synvisc injections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Herbal or Nutritional Supplements		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please list supplements:					

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

If yes, list:

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## ACTIVITIES OF DAILY LIVING

Do you have stairs to climb?  Yes  No If yes, how many? \_\_\_\_\_

How many people in household? \_\_\_\_\_ Relationship and age of each \_\_\_\_\_

Who does most of the housework? \_\_\_\_\_ Who does most of the shopping? \_\_\_\_\_ Who does most of the yard work? \_\_\_\_\_

On the scale below, circle a number which best describes your situation; *Most of the time, I function...*

1		2		3		4		5
VERY POORLY		POORLY		OK		WELL		VERY WELL

Because of health problems, do you have difficulty:  
(Please check the appropriate response for each question.)

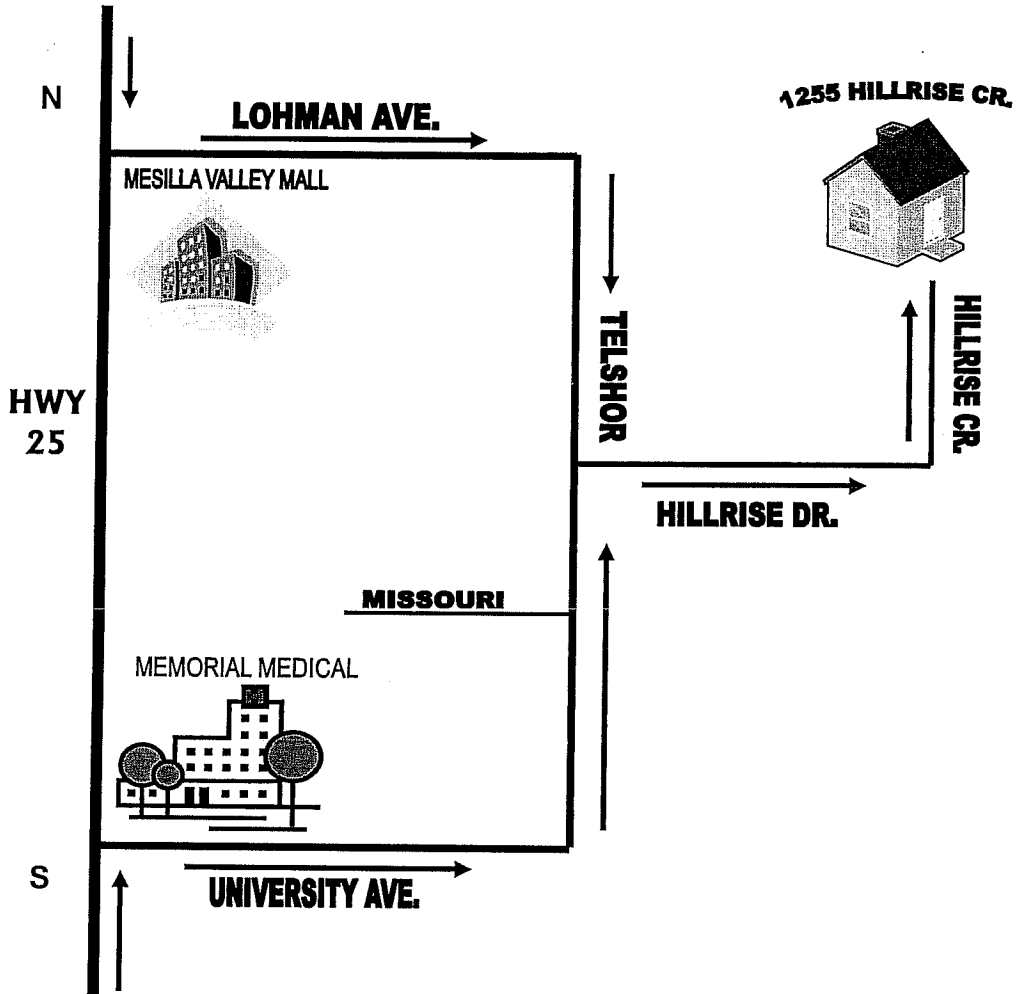
	Usually	Sometimes	No
Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Descending stairs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from chair?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your feet while seated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your back?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching behind your head?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staying asleep due to pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining restful sleep?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting along with family members?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your sexual relationship?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging in leisure time activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With morning stiffness?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane, crutches, as walker or a wheelchair? (circle one).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What is the hardest thing for you to do? \_\_\_\_\_

Are you receiving disability?..... Yes  No

Are you applying for disability?..... Yes  No

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



# ARTHRITIS AND OSTEOPOROSIS ASSOCIATES