

Date ___/___/___
 Time In _____ Out _____
 Dx: _____

Constitutional Symptoms	
Fever	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>
AM Stiffness(min)	
ACR- FC (circle)	I II III IV
VAS (0-10)	
Interval Hx (check)	
New Family Hx	

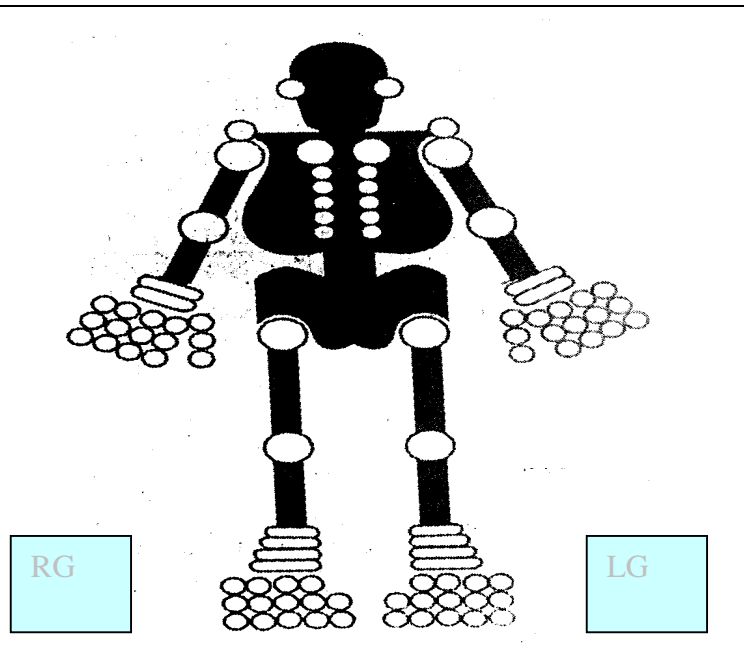
EAF			
Sicca	<input type="checkbox"/>	Resp	<input type="checkbox"/>
Nodules	<input type="checkbox"/>	Raynauds	<input type="checkbox"/>
Neuro	<input type="checkbox"/>	Ocular	<input type="checkbox"/>
Skin	<input type="checkbox"/>	GI	<input type="checkbox"/>
MM	<input type="checkbox"/>	GU	<input type="checkbox"/>
Other:			

Lab/ Serology	_____

Medications	_____

Issues:

P/E	
Height	_____
Weight	_____
BP	___/___
PR	_____
Gen Px	



Joint Count:	
#Tender	_____
#Swollen	_____
#Damage	_____
DAS SCORE = _____	
Axial:	
Cervical Rotation	
Wall-tragus	<input type="checkbox"/>
Finger to Floor	<input type="checkbox"/>
Chest Expansion	<input type="checkbox"/>
Th-Lum Rot'n	<input type="checkbox"/>
10's/Shober	<input type="checkbox"/>
Lat Flexion	(r) _____ (l) _____
Inter Mall Dist	<input type="checkbox"/>

Assessment/ Counselling Issues:

Staff note _____

Investigations:

Follow up? _____ Dictation # _____ Note dictated: Y / N (___ / ___ / ___)

Signature _____ Date ___/___/___