AMERICAN COLLEGE OF RHEUMATOLOGY
Patient History Update

What has happened since you were last here?

Name_____ **Age**_____

Since your last visit, have you?	**Yes**	**No**	**If yes, please specify**
Had any illnesses?	❑	❑	_____
Seen any health care providers?	❑	❑	_____
Had any x-ray, lab or other procedures	❑	❑	_____
Had any change in your family medical history?	❑	❑	_____
Had any change in your social history?	❑	❑	_____
Had any new allergies or reactions to medications?	❑	❑	_____
Started, changed or stopped any medications?	❑	❑	_____

New diseases or illnesses developed by relatives (parents, children, aunts, uncles, brothers, sisters)	**Changes in your social situation: Work, relationships, residence, smoking, alcohol consumption**	**New allergies or reactions to medications**

Please list any medications which are new, changed or stopped since your last visit

Name of Medication	**New, Change Or Stop** (For dose change, indicate current dosage)	**Name of prescribing doctor.** If you made the change, put Self	**Why was the medication changed or stopped?** No longer needed? No longer effective or not ever effective? Side effects (please specify)?

How Do You Feel Today as Compared to Your Last Visit Here?

Please rate the following items using this scale:

0=Problem not present today **1**=Much better **2**=Better **3**=Same **4**=Worse **5**=Much Worse **N**=New Problem

Pain:	Swelling:	Fatigue:	Ringing in Ears:	Stomach Upset:	Skin Rash:	Bruising:	Difficulty Sleeping:	Cough:
Eyes Red:	Chest Pain:	Fever:	Oral Ulcers:	Diarrhea:	Skin Ulcers:	Swollen Glands:	Headache:	Shortness of Breath:
Eyes Dry:	Heart Palpitations:	Weight Loss:	Overall Assessment:					

How long is your morning stiffness (minutes)? _____ What is your worst joint?_____

Patient's Name _____ Date _____ Physician Initials _____

Revised Fibromyalgia Impact Questionnaire (FIQR)*

Name:_____ Date:_____/_____/_____

Directions: For each question, place an "X" in the circle that best indicates how much your fibromyalgia made it difficult to do each of the following activities during the past 7 days.

	No difficulty										Very difficult
Brush or comb your hair	0	1	2	3	4	5	6	7	8	9	10
Walk continuously for 20 minutes	0	1	2	3	4	5	6	7	8	9	10
Prepare a homemade meal	0	1	2	3	4	5	6	7	8	9	10
Vacuum, scrub or sweep floors	0	1	2	3	4	5	6	7	8	9	10
Lift and carry a bag full of groceries	0	1	2	3	4	5	6	7	8	9	10
Climb one flight of stairs	0	1	2	3	4	5	6	7	8	9	10
Change bed sheets	0	1	2	3	4	5	6	7	8	9	10
Sit in a chair for 45 minutes	0	1	2	3	4	5	6	7	8	9	10
Go shopping for groceries	0	1	2	3	4	5	6	7	8	9	10

(for internal use only) Function subtotal ☐ Modified subtotal (divide by 3) ☐

Directions: For each question, place an "X" in the circle that best indicates the overall impact of your fibromyalgia over the past 7 days.

	Never										Always
Fibromyalgia prevented me from accomplishing goals for the week	0	1	2	3	4	5	6	7	8	9	10
I was completely overwhelmed by my fibromyalgia symptoms	0	1	2	3	4	5	6	7	8	9	10

(for internal use only) Overall impact subtotal ☐ Modified subtotal (divide by 1) ☐

(additional questions continued on back ➢)

Directions: For each of the following 10 questions, place an "X" in the circle that best indicates the intensity of your fibromyalgia symptoms over the past 7 days.

Please rate your level of pain

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Unbearable pain

Please rate your level of energy

Lots of energy (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) No energy

Please rate your level of stiffness

No stiffness (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Severe stiffness

Please rate the quality of your sleep

Awoke well rested (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Awoke very tired

Please rate your level of depression

No depression (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very depressed

Please rate your level of memory problems

Good memory (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very poor memory

Please rate your level of anxiety

Not anxious (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very anxious

Please rate your level of tenderness to touch

No tenderness (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Very tender

Please rate your level of balance problems

No imbalance (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Severe imbalance

Please rate your level of sensitivity to loud noises, bright lights, odors and cold

No sensitivity (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Extreme sensitivity

(for internal use only) Symptom subtotal ____ Modified subtotal (divide by 2) ____

FIQR TOTAL SCORE (sum of 3 modified domains) ____

*Adapted from: Bennett RM, et al. *Arthritis Res Ther.* 2009;11:R120.

Name: _____ **Date:** _____

Lilly
Answers That Matter.