OU Children's Physicians

OU Children's Physicians Pediatric Arthritis Center

Please complete the following questionnaire for your child:

Patient Name:	Birth Date:
Parent/Caretaker Name:	Primary Care Physician (Full Name, City, & State)
Mother's Occupation: Fathers' Occupation:	
Name of School:	Teacher/Contact: Grade/Year of study:

I. 1. Reason for your visit:

2. How long have you had this problem?

II. 1. Do you have fever? Yes / No
   a. If yes, what is the actual temperature? _________
   b. How long does the fever last? ______________

2. Do you have shaking chills with the fever? Yes/No

3. How many times have your symptoms occurred? _________________
   _______ per day _______ in the past weeks _______ in the past months

4. Do you have joint stiffness? Yes / No
   a. In the mornings? Yes / No After exercise or activity? Yes / No
   b. How long does the stiffness last? (minutes/hours) _____________
   c. What do you do for the stiffness? ___________________________

5. Do your joints become: Visibly swollen? Yes / No Warm? Yes / No Reddened? Yes / No Tender or painful to move? Yes / No
   a. If so, which joints are affected? ____________________________
   b. How long (hours, days, or weeks) do the joint changes last? ________________________
   c. Do the joint changes persist in the same joint(s), or do the changes move around from joint to joint? ______________________________

6. Do you awaken at night with the pain? Yes / No

7. Do you have joint pain especially after exercise or activity? Yes / No

8. What do you do for the joint problems?

9. Do you have a lot of fatigue? Yes / No
   a. How long does the fatigue last? _______________
   b. How much sleep do you get each night? _______ hours
   c. Do you also need daytime sleep due to fatigue? Yes / No

10. Have you lost weight? Yes / No If so, how much? ________

11. Do you miss school? Yes / No How many days in the last month(s)? __________

12. Are you able to keep up with the activities of your peers? Yes / No

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13. When you have joint problems, fever, or excessive fatigue, do you also have any of the following symptoms?

	Yes	No	
a.	☐	☐	Body rash (location ____)
b.	☐	☐	Facial rash
c.	☐	☐	Skin ulcers (location ____)
d.	☐	☐	Easy bruising
e.	☐	☐	Chest pain
f.	☐	☐	Painful breathing
g.	☐	☐	Abdominal pain
h.	☐	☐	Bloody stools
i.	☐	☐	Pink or bloody urine
j.	☐	☐	Low back pain
k.	☐	☐	Heel pain
l.	☐	☐	Muscle weakness
m.	☐	☐	Muscle pain
n.	☐	☐	Eye problems (redness, blurred vision, or light sensitivity)
o.	☐	☐	Other: ____

III. 1. What are your known medical problems?

2. What prior surgeries have you had (include circumcision, tonsillectomy, etc.)?

3. What medicines do you currently take? Please list the drug, dose, and frequency:

4. Are you allergic to any medicine? (Please list)

5. Have you ever been hospitalized? Yes / No
   a. Please list the dates and reason for hospitalization:

6. Are you up to date with your immunizations? Yes / No
   a. When was your last TB screening test?

7. Have you been traveling recently? Yes / No If so where?

8. Have you been in an area known to be inhabited by deer? Yes / No

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IV. 1. Do any family members have any of the following medical problems? If yes, please indicate the family member.

	Yes	No	
a.	☐	☐	Rheumatoid arthritis (adult onset)
b.	☐	☐	Childhood onset arthritis
c.	☐	☐	Lupus
d.	☐	☐	Immune deficiency (chronic infection)
e.	☐	☐	Colitis/Inflammatory bowel disease
f.	☐	☐	Ankylosing spondylitis
g.	☐	☐	Psoriasis
h.	☐	☐	Hemophilia or other bleeding disorder
i.	☐	☐	Knee pain
j.	☐	☐	Low back pain
k.	☐	☐	Heel pain
l.	☐	☐	Inflammation of the eye
m.	☐	☐	Diabetes
n.	☐	☐	Other autoimmune disease (thyroid, adrenal, liver)
o.	☐	☐	Cancer
p.	☐	☐	Multiple sclerosis
q.	☐	☐	Myasthenia gravis
r.	☐	☐	"Growing pains"
s.	☐	☐	Excessively mobile joints
t.	☐	☐	Rheumatic fever

V. 1. Have you had any of the following occur with your main problem?

	Yes	No	
a.	☐	☐	Rash which occurs in sun-exposed areas of your body
b.	☐	☐	Skin tightening
c.	☐	☐	Skin discoloration
d.	☐	☐	Hair loss
e.	☐	☐	Headache
f.	☐	☐	Jaw pain
g.	☐	☐	Sudden paleness of the skin (fingers, hand, toes, earlobe, nose) with or without exposure to cold
h.	☐	☐	Dry eyes or mouth
i.	☐	☐	Mouth or nose ulcers
j.	☐	☐	Sore throat
k.	☐	☐	Persistent cough
l.	☐	☐	Coughing up blood
m.	☐	☐	Difficulty swallowing
n.	☐	☐	Nausea or vomiting
o.	☐	☐	Heartburn
p.	☐	☐	Constipation
q.	☐	☐	Diarrhea
r.	☐	☐	Genital ulcers
s.	☐	☐	Genital discharge
t.	☐	☐	Seizures
u.	☐	☐	Tingling, burning or numbness of hands, face, or feet
v.	☐	☐	Psychological disturbances/personality changes

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VI.

1. Do you have a known exposure to any environmental pollutants or hazards?
2. Do you perform any physically repetitive tasks at school, home, or work? Examples would include playing video games, prolonged typing, etc.
3. Please list your brothers' and sisters' full names, and please note if they have any medical problems.
4. I participate in individual and/or team sports:
5. I am unable to do the following activities that I would normally do:
6. Please list any adaptive equipment you currently use:
7. Are you currently using any splints or orthotic devices? If so, please indicate which items you use:
8. Do you do any physical therapy? If so, please list how often this is performed:
9. I have also seen the following specialist doctors for this problem: