CONFIDENTIAL

RHEUMATRY RA REGISTRATION QUESTIONNAIRE

DEMOGRAPHIC INFORMATION:

National Code*:	**Date*:**	**Physician Name:**
Hospital Document ID:	**Rheumatry ID:**	
First Name (EN)*:	**Last Name (EN)*:**	
Full Name in Local Language*:		
Gender*: M☐ F☐	**Date of Birth*:**	**Place of Birth:**

Address Type: Urban☐ Rural☐

Province: ---------- **City:** ----------

Address: ----------

Phone number*: ---------- **Mobile*:** ----------

E-mail address: ----------

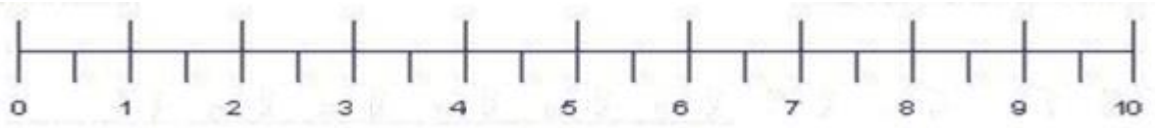
First Job: **Working Hours/Day:** **Shift Work:** Fix☐ Rotation☐

Second Job: **Working Hours/Day:** **Shift Work:** Fix☐ Rotation☐

Job History:

Row	Job Experiences	Time of Employment (Month)	Cause of Job Change
1			
2			
3			

Job Stress:



Physical Activity: Inactive☐ Mild☐ Moderate☐ Severe☐

Education: Illiterate☐ Read and Write☐ Primary School☐ Secondary School☐ High School☐ Diploma☐ Theological Studies ☐ University Degree☐

If yes: Technician☐ BSc/BA☐ MSc/MA☐ MD☐ PhD☐ **Field:** ----------

Mother Ethnicity:

Fars☐ Turk☐ Kurd☐ Lor☐ Gilak☐ Mazani☐ Baluch☐ Turkoman☐ Arab☐ Armenian☐ Zoroastrian☐ Christian☐ Jewish☐ Other: -------

Father Ethnicity:

Fars☐ Turk☐ Kurd☐ Lor☐ Gilak☐ Mazani☐ Baluch☐ Turkoman☐ Arab☐ Armenian☐ Zoroastrian☐ Christian☐ Jewish☐ Other: -------

Marital Status: Single☐ Married☐ Widowed☐ Divorced☐

Blood Group: A☐ B☐ AB☐ O☐ Rh+☐ Rh-☐

Date of First Visit in the Center:

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PERSONAL HISTORY:

Smoking (1 Pipe = 2.5 Cigarettes)**:**

Non Smoker □	**Smoker** □	
Passive Smoker □	**Former** □ Date of Start: ---------- Date of Quit: ---------- Cigarettes/Day:----------	**Current** □ Date of Start: ---------- Cigarettes/Day:----------

Bubble Hubble: No□ Yes□

Alcohol: No □ Yes□ **If yes:** Daily□ 1-3/Week□ 1-4/Month□ Infrequently□
Type: ---------- Volume: --------- No. of Units: ----------
(A unit of alcohol is equivalent to a standard glass of beer (285ml), a single measure of spirits (30ml), a medium-sized glass of wine (120ml), or 1 measure of an aperitif (60ml)).

Illicit Drugs: No□ Yes□ **If yes:** Opium□ Hash□ Chrystal Meth□ Heroin□ Cocaine□ Marijuana□ Methadone□ Other: ----------

Allergy to Drugs: No□ Yes□ **Drug(s) Name: ----------**

Bone Fracture History: No□ Yes□ **Location: ---------- Comment: ----------**

Date of Disease Onset: ---------- **Date of Diagnosis: ----------**
Place of Living at the Disease Onset: ----------

Poor Compliance to Medication: No□ Yes□

Overlap Syndrome: No□ Yes□ **If yes please mark it:**

Type	**No/Yes**	**Date**	**Type**	**No/Yes**	**Date**
Antiphospholipid Syndrome	No□ Yes□		Seronegative Arthropathy	No□ Yes□	
Scleroderma	No□ Yes□		Vasculitis	No□ Yes□	
Systemic Lupus Erythematosus	No□ Yes□		Behcet Disease	No□ Yes□	
Sjogren	No□ Yes□		Hypothyroidism	No□ Yes□	
Polymyositis	No□ Yes□		Dermatomyosis	No□ Yes□	
Diabetes Mellitus	No□ Yes□		Hyperthyroidism	No□ Yes□	
MCTD	No□ Yes□		Multiple Sclerosis	No□ Yes□	
Ankylosing Spondylitis	No□ Yes□		Other:		

Pregnancy: No□ Yes□

Are You Pregnant? No□ Yes□
Number of Pregnancy: --------- **Age of First Pregnancy: ----------** **Age of Second Pregnancy: ----------** **Age of Third Pregnancy: ---------**
Number of Children: ----------
Fetal Loss: No□ Yes□ **If yes, Number of Fetal Loss: ----------**
Premature Infants: No□ Yes□ **If yes, Number of Premature Infants: ----------**
Contraception Method: Natural□ OCP□ IUD□ Other: ----------
Was your first pregnancy after RA onset? No□ Yes□
Pregnancy during your RA course: No□ Yes□
Effect of pregnancy on your RA disease in **first** trimester: Improved□ Remission□ Persistent□ Flare□
Effect of pregnancy on your RA disease in **second** trimester: Improved□ Remission□ Persistent□ Flare□
Effect of pregnancy on your RA disease in **third** trimester: Improved□ Remission□ Persistent□ Flare□
Postpartum Flare: No□ Yes□ **If yes:** Before three months□ After three months□

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PAST MEDICAL HISTORY: No☐ Yes☐ **If yes please mark it:**

Category	Abnormality	No/Yes	Date of Onset	Category	Abnormality	No/Yes	Date of Onset
Metabolic (Endocrine) Disorder	Amenorrhea	No☐ Yes☐		**GI**	Fatty Liver	No☐ Yes☐	
	Hypercholesterolemia	No☐ Yes☐			Peptic Ulcer	No☐ Yes☐	
	Hypertriglyceridemia	No☐ Yes☐			IBD	No☐ Yes☐	
	Diabetes Insipidus	No☐ Yes☐			IBS	No☐ Yes☐	
	Hyperthyroidism	No☐ Yes☐			Viral Hepatitis	No☐ Yes☐	
	Hypothyroidism	No☐ Yes☐			Other		
	Subacute Thyroiditis	No☐ Yes☐		**Respiratory**	Asthma	No☐ Yes☐	
	Cushingoid Appearance	No☐ Yes☐			Allergy	No☐ Yes☐	
	Diabetes	No☐ Yes☐			COPD	No☐ Yes☐	
	Hypogonadism	No☐ Yes☐			Bronchiectasis	No☐ Yes☐	
	Hypergonadism	No☐ Yes☐			TB	No☐ Yes☐	
	Other				ILD	No☐ Yes☐	
Cardiac (CAD)	CHF	No☐ Yes☐			PTE	No☐ Yes☐	
	Hypertension	No☐ Yes☐			Pneumonia	No☐ Yes☐	
	IHD	No☐ Yes☐			Other		
	IHD- CABG	No☐ Yes☐		**Eye**	Cataract	No☐ Yes☐	
	IHD- MI	No☐ Yes☐			Glaucoma	No☐ Yes☐	
	IHD- Stent	No☐ Yes☐			Conjunctivitis	No☐ Yes☐	
	Other				Other		
Bone and Muscle	Osteoporosis	No☐ Yes☐		**Skin**	Pyoderma	No☐ Yes☐	
	OA	No☐ Yes☐			Erythema Nodosum	No☐ Yes☐	
	Myopathy	No☐ Yes☐			Hives	No☐ Yes☐	
	Aseptic Necrosis	No☐ Yes☐			Seborrheic Dermatitis	No☐ Yes☐	
	Osteomyelitis	No☐ Yes☐			Other		
	Vitamin D Deficiency	No☐ Yes☐		**CNS**	CVA	No☐ Yes☐	
	Septic Arthritis	No☐ Yes☐			Optic Neuritis	No☐ Yes☐	
	Other				MS	No☐ Yes☐	
Hematologic	Anemia	No☐ Yes☐			NMO	No☐ Yes☐	
	Transfusion	No☐ Yes☐			Epilepsy	No☐ Yes☐	
	Felty Syndrome	No☐ Yes☐			Other		
	Other			**Congenital Disorder**	No☐ Yes ☐ **If yes,** Type: ----------		
Malignancy	No☐ Yes ☐ **If yes,** Type: ----------						
Vaccination (From one year ago)	No☐ Yes ☐ **If yes,** Type: ----------						

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COMORBIDITY: No☐ Yes☐ If yes please mark it:

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	Hypertriglyceridemia	No☐ Yes☐			IBD	No☐ Yes☐	
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	Hyperthyroidism	No☐ Yes☐			Viral Hepatitis	No☐ Yes☐	
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	Subacute Thyroiditis	No☐ Yes☐		**Respiratory**	Asthma	No☐ Yes☐	
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	Hypergonadism	No☐ Yes☐			TB	No☐ Yes☐	
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	IHD- MI	No☐ Yes☐			Glaucoma	No☐ Yes☐	
	IHD- Stent	No☐ Yes☐			Conjunctivitis	No☐ Yes☐	
	Other				Other		
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	OA	No☐ Yes☐			Erythema Nodosum	No☐ Yes☐	
	Myopathy	No☐ Yes☐			Hives	No☐ Yes☐	
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Hematologic	Anemia	No☐ Yes☐			NMO	No☐ Yes☐	
	Transfusion	No☐ Yes☐			Epilepsy	No☐ Yes☐	
	Felty Syndrome	No☐ Yes☐			Other		
	Other			**Congenital Disorder**	No☐ Yes ☐ **If yes,** Type: ----------		
Malignancy	No☐ Yes ☐ **If yes,** Type: ----------						

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FAMILIAL HISTORY: No☐ Yes☐ **If yes please mark it:**

Disease	Mother	Father	Brother	Sister	Son	Daughter	Grand Mother		Grand Father		Aunt		Uncle		Niece	Nephew	Grand Child		Other
							Maternal	Paternal	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal			Son	Daughter	
Rheumatic Diseases																			
RA																			
Sjogren																			
SLE																			
APS																			
AS																			
SpA																			
Reactive RA																			
Scleroderma																			
MCTD																			
Behcet's Disease																			
Vasculitis																			
Gout																			
PM																			
DM																			
Undifferentiated Arthritis																			
Non-Rheumatic Diseases																			
OA																			
OP																			
IBD																			
Hyperthyroidism																			
Hypothyroidism																			
Multiple Sclerosis																			
Type 1 Diabetes																			
Type 2 Diabetes																			
Atherosclerosis(Male< 60 Y and Female<50 Y)																			
Celiac Disease																			
Vitiligo																			
Primary HTN																			
Secondary HTN																			
Other																			

Twin: No☐ Yes☐
If Yes: Monozygotic☐ Dizygotic, Brother☐ Dizygotic, Sister☐
Does your twin Brother/Sister have autoimmune disease? No☐ Yes☐ **If yes, Type:** ----------

Consanguineous Marriage: No☐ Yes☐
If yes: Father and Mother ☐ Grandfather and Grandmother ☐ Patient and Spouse ☐
(First Degree☐ Second Degree☐) (First Degree☐ Second Degree☐) (First Degree☐ Second Degree☐)

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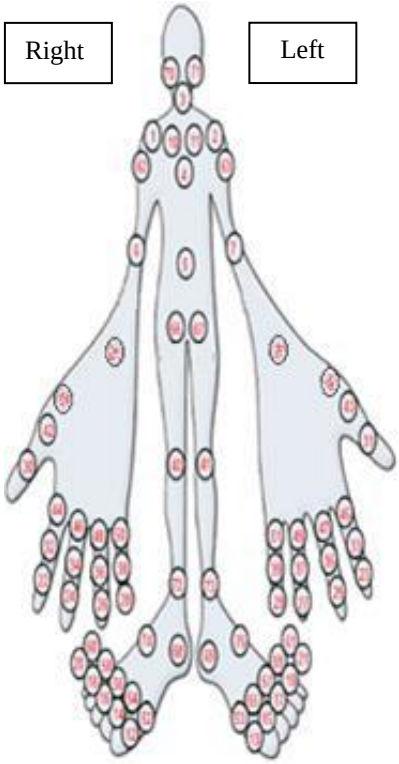
SURGERY / INJECTION:

Surgery: No□ Yes□

Corticosteroid Injection: No□ Yes□

Right Left



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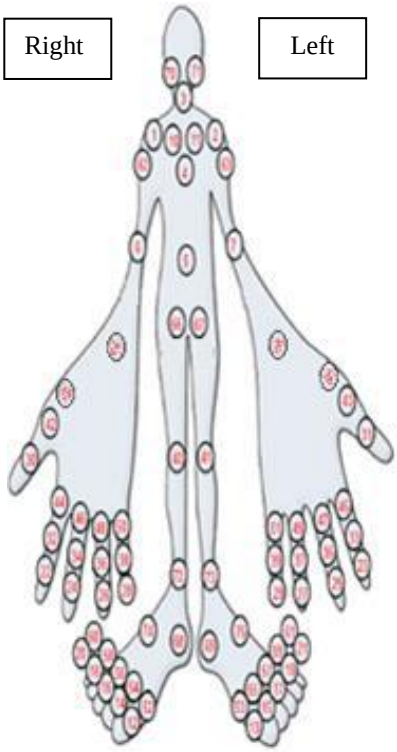

Surgery:

Type		Date	Remark
Articular Surgery	Joint Replacement		
	Arthroscopy		
	Synovectomy		
	Arthrodesis		
	Lavage		
	Other		
Periarticular Surgery	Carpal Tunnel Syndrome		
	Tenosynovectomy		
	Tendon Repair		
	Other		

Corticosteroid Injection:

Location		Date	Remark
Articular			
Periarticular	Ganglion		
	Baker Cyst		
	Other		

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PAST DRUG HISTORY:

Row	Generic Name	Trademark Name	X (X= Number of Drug for Each Time)	Y & Z (Y= How Many Times Per Z Days)	Strength	Start Date	Stop Date	Reason to Stop								Remark
								No Response	Pregnancy	Infection	Surgery	No Compliance	According to Physician Comment	Adverse Effect *	Other	
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																
16																
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21																
22																
23																
23																

***Physicians or registrars should ask about the adverse effect type and the severity of adverse effect according to Rheumatry registry website, Past Medical History part.**

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PRESENT MEDICATION:

Row	Generic Name	Trademark Name	X (X= Number of Drug for Each Time)	Y & Z (Y= How Many Times Per Z Days)	Strength	Start Date	Remark
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

CLINICAL EVALUATION:

Onset:

Acute□ Insidious□ Duration ____Days/Weeks/Months/Years **(Acute: <6 weeks, Insidious: >6 weeks)**

First symptoms: Arthritis and Arthralgia□ Fever□ Constitutional□ Other ----------

Initial site: Joint□ Soft Tissue□ Extra-Articular□

Pattern: Mono□ Oligo□ Polyarticular□(Symmetrical□ Asymmetrical□) Palindromic□ Other: --------

If Polyarticular: Additive□ Migratory□ Intermittent□

Relapse Course Duration: ---------- (Weeks)

PHYSICAL EXAMINATION AND REVIEW OF SYSTEMS:

Physical Examination:

Temp: --------- **Pulse:** --------

Blood Pressure (Right) (mmHg): --------- **Blood Pressure (Left) (mmHg):** --------

Height: -------- **(cm)** **Weight:** --------- **(kg)** **BMI:** ----------

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Constitutional	Fever□ Weight Loss (10% Weight During 6 Months)□ (If yes: -----kg/month), Anorexia□ Fatigue□ Malaise□ Night Sweat□ Other ----------
Eye	Episcleritis□ Scleritis□ Iridocyclitis□ Anterior Uveitis□ Post Uveitis□ Dryness□ Vasculitis□ Scleromalacia□ Keratoconjunctivitis Sicca□ Redness□ Itching□ Pain□ Blurred Vision□ Conjunctivitis□ Visual Loss□ Double Vision□ Icteric□ Lacrimation□ Other ----------
Ear-Nose-Mouth-Throat	Dryness in Mouth□ Loss of Hearing□ Bleeding□ Sore Throat□ Hoarseness□ Periodontitis□ Ulcer□ Gingivitis□ Ear Discharge□ Thyromegaly□ Post-Nasal Discharge□ Nasal Polyp□ Tinnitus□ Olfactory Disorder□ Other ----------
Skin	Rheumatoid Nodule□ Petechia□ Purpura□ Hair Loss□ Splinter Hemorrhage□ Nail Pitting□ Nail Fungal□ Periungual Erythema□ Ulcer□ Hyperpigmentation□ Hypopigmentation□ Raynaud□ Photosensitivity□ Alopecia□ Livedo Reticularis□ Papule□ Macule□ Clubbing□ Easy Bruising□ Other ----------
Cardiovascular	Chest Pain□ Pericardial Effusion□ Endocarditis□ Palpitation□ Souffle□ Varicose□ Arrhythmia□ CHF□ CABG□ Stent□ Syncope□ Cyanosis□ Other ----------
Lung	Dyspnea□ Pleural Effusion□ Sputum□ Hemoptysis□ Nodule□ RA-ILD□ Cough□ Wheezing□ Crackle□ Other ----------
Gastrointestinal	Abdominal Pain□ Nausea□ Vomiting□ Heart Burn□ Dysphagia□ Odynophagia□ Diarrhea□ Constipation□ Hepatomegaly□ Splenomegaly□ Hemorrhoids□ Melena□ Tenderness□ Ascites□ Anorexia□ Other ----------
Neurological/ Psychiatric	Carpal Tunnel Syndrome□ Paresthesia□ Seizures□ Mood Disorder□ Headache□ Insomnia□ Dizziness□ Muscle Spasm□ Memory Loss□ Agitation□ Numbness□ Tremor□ Drowsiness□ Central Neuropathy□ Cranial Neuropathy□ Peripheral Neuropathy□ Snoring□ Other ----------
Musculoskeletal	Weakness□ Joint Pain□ Osteoarthritis□ Muscle Pain□ Pitting Edema□ DVT□ Amputation□ Low Back Pain□ Sarcopenia□ Atrophy□ Other ----------
Hematologic/ Lymph Node	Lymphadenopathy□ Anemia□ Other ----------
Renal	Glomerulonephritis□ Interstitial Nephritis□ Renal Tubular Nephritis□ Renal Stone□ Acute Kidney Failure□ Chronic Kidney Failure□ Polycystic Kidney Disease□ Uremia□ Amyloidosis□ ESRD□ Other ----------
Genitourinary	Dysuria□ Frequency□ Hematuria□ Discharge□ Ulcer□ Impotency□ Vaginal Dryness□ Infertility□ Menorrhagia□ UTI□ Other ----------
	Menopause: No□ Yes□ If yes date: ----------
	Menses: Regular□ Irregular □ Other ----------
Breast	Pain□ Nipple Discharge□ Mass□ Other ----------

Muscle Force Score:

	Location			**Score (1-5)**
Weakness	Upper Limb	Proximal	Right	
			Left	
		Distal	Right	
			Left	
	Lower Limb	Proximal	Right	
			Left	
		Distal	Right	
			Left	

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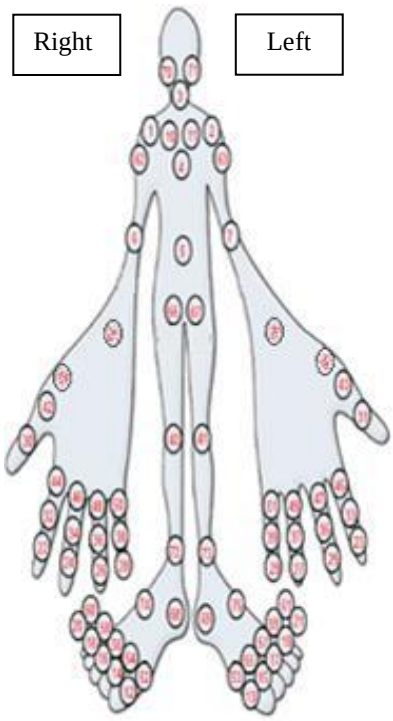
JOINT EVALUATION: No☐ Yes☐

If yes please mark the severity of Swelling, Tenderness and Limitation from 1 to 4 plus

Swelling Count

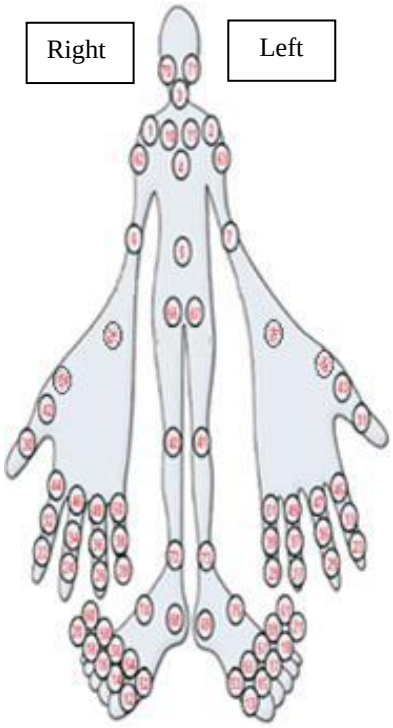
Right Left



Total Swelling Joints: ---------

Pain Tenderness Count

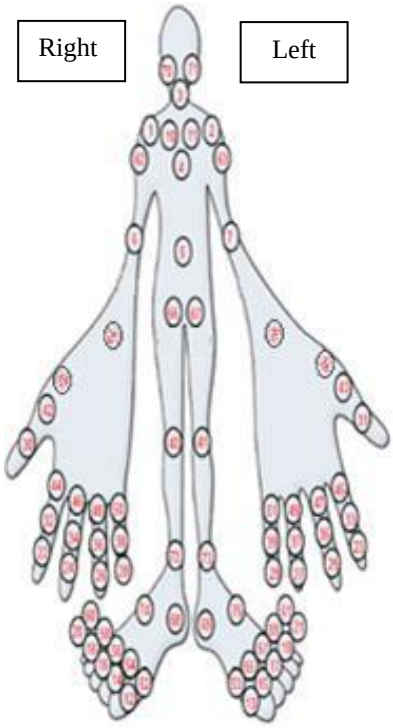
Right Left



Total Painful Joints: ---------

Limitation

Right Left



SKELETAL DEFORMITIES: No☐ Yes☐ If yes please mark it:

Deformity	No/Yes	Right	Left	Remark
Ulnar Deviation	No☐ Yes ☐			
Z Deformity	No☐ Yes ☐			
Flesam Knee	No☐ Yes ☐			
Flesam Elbow	No☐ Yes ☐			
Piano Key Styloid	No☐ Yes ☐			
Boutonniere	No☐ Yes ☐			
Swan Neck	No☐ Yes ☐			
Subluxation (MCP)	No☐ Yes ☐			
Subluxation (Wrist)	No☐ Yes ☐			
Genu Valgus	No☐ Yes ☐			
Genu Varus	No☐ Yes ☐			
Hallux Rigidus	No☐ Yes ☐			
Hallux Valgus	No☐ Yes ☐			
Over Ridding	No☐ Yes ☐			
Heberden Node	No☐ Yes ☐			
Bouchard Node	No☐ Yes ☐			
Hypertrophic Malleolar	No☐ Yes ☐			
Kyphosis	No☐ Yes ☐	-		
Scoliosis	No☐ Yes ☐	-		

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LABORATORY MEASUREMENTS:

Category	Lab Tests	Result	Range	Unit	Interpretation			
					Low	Normal	High (+/++/+++)	Pos/Neg
Hematology and Coagulation	WBC							
	Lymphocyte							
	Neutrophil							
	Eosinophil							
	Basophil							
	RBC							
	Retic							
	Hb							
	HCT							
	MCV							
	Plt							
	ESR							
	PT							
	PTT							
	INR							
Biochemistry	FBS							
	TG							
	Cholesterol							
	HDL							
	LDL							
	BUN							
	Cr							
	Uric Acid							
	AST							
	ALT							
	ALP							
	CPK							
	LDH							
	Albumin							
	Iron							
Serology	CRP							
	PPD							
	Wright							
	Coombs Wright							
	Widal							

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	2ME							
	RF							
Immunology	Anti-CCP							
	FANA							
	ANA							
	Anti-dsDNA							
	Anti-MCV							
	C3							
	C4							
	CH50							
	TSH							
	T3							
	T4							
	Anti-TPO							
	Ferritin							
	PTH							
	Procalcitonin							
	IGRA							
Viral	Hbs-Ag							
	HBV-Ab							
	HCV-Ab							
	HIV-Ab							
Elec and Vitamin	Ca							
	P							
	25OH-VitD (ng)							
Genetic	HLA-B27							
Urine Analysis	RBC							
	WBC							
	Granular Cast							
	RBC Dysmorphic							
	Urine Protein (+)							
	Urine Blood (+)							
	pH							
	Specific Gravity							
	Culture (+/-)							
24 Hours Urine Analysis	Volume							
	Protein							
	Cr							
	Ca							
	P							

Laboratory Name: ---------- Laboratory City: ---------- Date: ----------

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DIAGNOSIS CRITERIA (ACR CLASSIFICATION)*:

2010 ACR / EULAR Rheumatoid Arthritis Classification Criteria

A. Joint Involvement	**Date of Onset**	**Point Score**
1 large joint		0
2−10 large joints		1
1−3 small joints (with or without involvement of large joints)		2
4−10 small joints (with or without involvement of large joints)		3
>10 joints (at least one small joint)		5
B. Serology (at least 1 test result is needed for classification)		
Negative RF *and* negative ACPA		0
Low-positive RF *or* low-positive ACPA		2
High-positive RF *or* high-positive ACPA		3
C. Acute-Phase Reactants (at least one test result is needed for classification)		
Normal CRP *and* normal ESR		0
Abnormal CRP *or* abnormal ESR		1
D. Duration of Symptoms		
<6 weeks		0
≥6 weeks		1

Definite RA ≥6 scores

1987ACR Rheumatoid Arthritis Classification Criteria

Items	**Date of Onset**	**Point Score**
Morning stiffness		1
Arthritis of three or more joint areas		1
Hand joint involvement		1
Symmetric arthritis		1
Rheumatoid nodules		1
Serum rheumatoid factor positive		1
Radiographic changes		1

Definite RA ≥4 points

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Persian version of the Stanford Health Assessment Questionnaire (HAQ) in patients with rheumatoid arthritis: No□ Yes□ **If yes please mark it:**

Row	Dressing: Are you able to:	Without any difficulty	With some difficulty	With much difficulty	Unable
1	Dress yourself, including shoelaces and buttons?	□	□	□	□
2	Shampoo your hair?	□	□	□	□
	Arising: Are you able to:				
3	Stand up from a straight chair?	□	□	□	□
4	Get up and down from Iranian style futon (a mattress on the floor)?	□	□	□	□
	Eating: Are you able to:				
5	Use spoons and forks?	□	□	□	□
6	Lift a full cup or glass to your mouth?	□	□	□	□
7	Open a new milk carton?	□	□	□	□
	Walking: Are you able to:				
8	Walk outdoors on flat ground?	□	□	□	□
9	Climb up five steps?	□	□	□	□
	Hygiene: Are you able to:				
10	Wash and dry your body?	□	□	□	□
11	Take a tub bath?	□	□	□	□
12	Go to a squat toilet by yourself?	□	□	□	□
	Reach: Are you able to:				
13	Reach and get down a 2.5 kg nylon pocket from just above your head?	□	□	□	□
14	Bend down to pick up clothing from the floor?	□	□	□	□
	Grip: Are you able to:				
15	Open car doors?	□	□	□	□
16	Open previously opened jars?	□	□	□	□
17	Turn faucets on and off?	□	□	□	□
	Activities: Are you able to:				
18	Run errands and shop?	□	□	□	□
19	Get in and out of a car?	□	□	□	□
20	Praying from the standing position (Kneeling)?	□	□	□	□

Please check any AIDS or DEVICES that the patient usually uses for any of these activities:
Cane□ Walker□ Crutches□ Wheelchair□ Special Built up Chair□ Raised Toilet Seat□

Categories for which the patient need HELP from another person:
Dressing and Grooming□ Arising□ Eating□ Walking□ Hygiene□ Reach□ Grip□ Activities□

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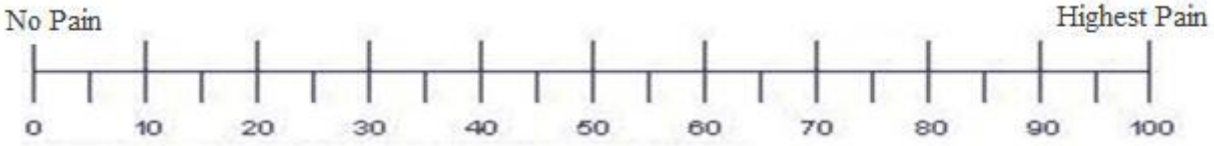
DISEASE ACTIVITY SCORE (DAS-28)

CRP: **ESR:**

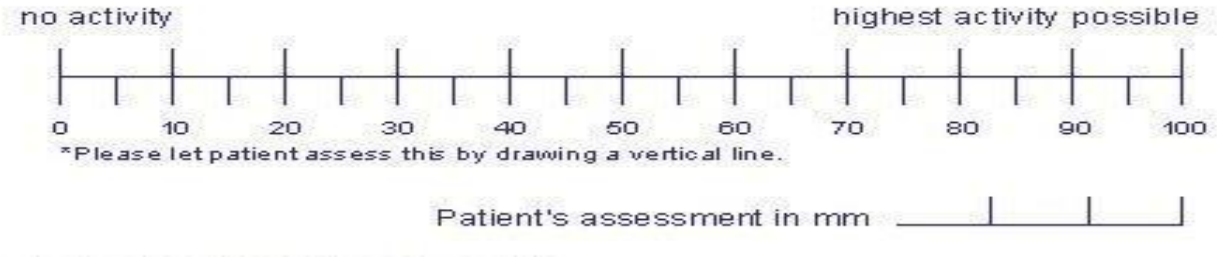
Pain Visual Analog Scale (VAS):

How was your pain in last 7 days?



Patient Global Assessment:

Considering all the effects of rheumatoid arthritis on you, show your health status by drawing a vertical line on the strip below:



PHYSICIAN GLOBAL ASSESSMENT:

Early Morning Stiffness: ---------- Minutes

Grip Strength (kg): RT: ---------- **LT:** ---------- **Fatigue:** ----------

Sleep: Normal☐ Disturbed☐ Excess☐ Mild Loss☐ Severe Loss☐

EYE EXAMINATION FOR ANTIMALARIAL DRUGS:

Vision	Left: --------- Right: ---------
Cornea	Punctate to Linear Opacities☐ Vortex Keratopathy☐ Bull's Eye☐
Retina	Atrophy☐ Abnormal Pigmentation☐ Loss of Foveal Reflex☐
Remark	Continue Antimalarial Drugs☐ Lower Dose of Antimalarial Drugs☐ Discontinue Antimalarial Drugs☐

Comment: ----------

---------- **Date:** ----------

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PARACLINIC EXAMINATION:

X-RAY AND IMAGING: No☐ Yes☐

Region	Subtype					Remark
	Osteophyte	Reduced Joint Space	Erosion	Ankylosis	Subluxation	
Wrist (Right)						
Wrist (Left)						
MCP (Right)						
MCP (Left)						
PIP (Right Hand)						
PIP (Left Hand)						
DIP (Right)						
DIP (Left)						
Elbow (Right)						
Elbow (Left)						
Shoulder (Right)						
Shoulder (Left)						
Neck						
Lumbar						
Sacroiliac (Right)						
Sacroiliac (Left)						
Knee (Right)						
Knee (Left)						
Ankle (Right)						
Ankle (Left)						
Hip (Right)						
Hip (Left)						
MTP (Right)						
MTP (Left)						
PIP (Right Foot)						
PIP (Left Foot)						
TM Joint (Right)						
TM Joint (Left)						

Comment: ----------

---------- **Date:** ----------

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BONE MINERAL DENSITY: No☐ Yes☐

Location	Date	T-Score	Z-Score	BMD (g/cm^2)
Femur Total				
Femur Neck				
Lumbar Spine (L1-L4)				
Lumbar Spine (L2-L4)				
1/3 Distal of the Radius				
TBS		Score:		

Device: Hologic☐ Lunar☐ Norland☐ Medilink☐ Other: --------- **Date:** ---------- **Place:** ----------

PULMONARY FUNCTION TEST: No☐ Yes☐

PFT	Actual	Predicted (%)
FEV1		
FVC		
FEV1/FVC		
MEF25-75		
MEFR		
Body Box	**Actual**	**Predicted (%)**
FEV1		
FVC		
FEV1/FVC		
MEF25-75		
TLC		
Raw		
SRaw		
TGV		
RV		
RV/TLC		
DLCO	**Actual**	**Predicted (%)**
TLC		
DLCO		
KCO		

Result: ----------

Specialist: ---------- **Date:** ----------

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CHEST CT-SCAN: No□ Yes□

Abnormality	No/Yes	Date of Onset	Remark
Lymphadenopathy	No□ Yes□		
Mass in Lung	No□ Yes□		
Nodule	No□ Yes□		
Pleural Effusion	No□ Yes□		Size: ---------- Unilateral □ Bilateral □
Pleural Thickening	No□ Yes□		
Shrinking Lung	No□ Yes□		
Pleural Fibrosis	No□ Yes□		
Pulmonary Infarction	No□ Yes□		
Calcification	No□ Yes□		
Bronchiectasia Tractional	No□ Yes□		
ILD	No□ Yes□		--------- % Reticular Pattern □ Bronchiectasia □ Honeycomb □
Ground Glass	No□ Yes□		≥20%□ <20%□
Alveolitis	No□ Yes□		Grade I□ II□ III□
Honeycombing	No□ Yes□		
Fibrotic Change	No□ Yes□		
Esophageal Dilatation	No□ Yes□		
Pneumonitis	No□ Yes□		

Pathology Result: ----------

---.

Specialist: ---------- **Date:** ---------- **PAX Number:** ---------- **Place:** ----------

Abdomen and Pelvis Ultrasound/ Sonography: No□ Yes□

Result: ----------

Date: ----------.

MRI: No□ Yes□

Result: ----------

---.

Date: ----------.

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ANGIOGRAPHY: No□ Yes□

Vessel Involvement	
Left Main	-------%
LAD	-------%
LCX	-------%
RCA	-------%
Result:	1 Vessel □ 2 Vessel □ 3 Vessel □
Plan	Medical Treatment PCI: 1 Vessel □ 2 Vessel □ CABG
Rt Cath	Systolic Pressure: -------- Diastolic Pressure: ------- Mean Pressure: --------
RA Pressure	
RV Pressure	
Aortic Pressure	
LVEDP	
P.C.W.P (Pulmonary Capillary Wedge Pressure)	
Cardiac Output	
Other	

Angiography Result: ----------

Specialist: ----------**Date:** ----------**Place:** ----------

PHYSICIAN COMMENT:

Chief Complaint: ----------

Disease Course: ----------

Overall Comment: Complete Remission□ Partial Remission□ Recurrent□ Flare□

Physician Name: **Signature:**

Registrar Name: **Signature:**

Lab Samples: DNA□ RNA□ Serum□

Next Visit Date:

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پرسشنامه Stanford (HAQ) فارسی

لطفا پاسخ‌هایی را که توانایی معمول شما را در هفته گذشته به بهترین شکل نشان می‌دهند، انتخاب کنید:

شماره	لباس پوشیدن: آیا شما می‌توانید:	بدون هیچ‌گونه مشکل	با کمی مشکل	با سختی زیاد	نمی‌توانم
۱	لباس‌هایتان را بپوشید، بند کفش‌ها و دگمه‌های لباس‌هایتان را ببندید؟	☐	☐	☐	☐
۲	موهای خود را بشویید؟	☐	☐	☐	☐
	بلند شدن: آیا شما می‌توانید:				
۳	از یک صندلی بدون دسته بلند شوید؟	☐	☐	☐	☐
٤	به تختخواب (یا رختخواب) بروید یا از آن بلند شوید؟	☐	☐	☐	☐
	خوردن: آیا شما می‌توانید:				
٥	از قاشق و چنگال به راحتی استفاده کنید؟	☐	☐	☐	☐
٦	یک لیوان یا استکان پر را تا دهان بالا ببرید؟	☐	☐	☐	☐
۷	یک بطری آب معدنی را باز کنید؟	☐	☐	☐	☐
	راه رفتن: آیا شما می‌توانید:				
۸	در بیرون از منزل بر روی یک سطح صاف پیاده‌روی کنید؟	☐	☐	☐	☐
۹	از ٥ پله بالا بروید؟	☐	☐	☐	☐
	بهداشت فردی: آیا شما می‌توانید:				
۱۰	کل بدن خود را بشویید و خشک کنید؟	☐	☐	☐	☐
۱۱	حمام بکنید (یا دوش بگیرید)؟	☐	☐	☐	☐
۱۲	بدون نیاز به کمک از دستشویی ایرانی استفاده کنید؟	☐	☐	☐	☐
	گرفتن: آیا شما می‌توانید:				
۱۳	بسته‌ای مانند یک کیسه نایلون ۲/٥ کیلویی را بگیرید و از بالای سر آن را روی زمین بگذارید؟	☐	☐	☐	☐
١٤	خم شوید و لباس خود را از روی زمین بردارید؟	☐	☐	☐	☐
	چنگ زدن: آیا شما می‌توانید:				
١٥	درب ماشین را باز کنید؟	☐	☐	☐	☐
١٦	در مربایی را که قبلا یکبار باز شده، دوباره باز کنید؟	☐	☐	☐	☐
۱۷	شیر آب را باز و بسته کنید؟	☐	☐	☐	☐
	فعالیت‌های دیگر: آیا شما می‌توانید:				
۱۸	بیرون بروید و کار خرید را انجام دهید؟	☐	☐	☐	☐
۱۹	سوار ماشین شوید و از ماشین پیاده شوید؟	☐	☐	☐	☐
۲۰	نماز را ایستاده بخوانید؟	☐	☐	☐	☐

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لطفا هر کدام از وسایلی را که معمولا برای انجام فعالیت‌های یاد شده استفاده می‌کنید، علامت بزنید:

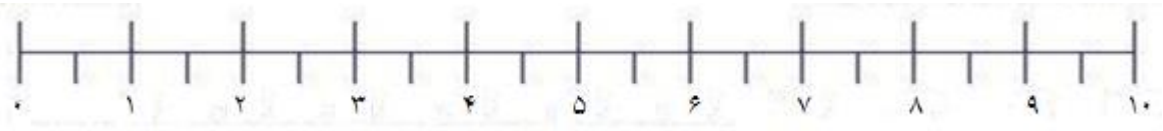
عصا☐ حفاظ پیاده‌روی☐ عصای آتل‌دار☐ صندلی چرخدار☐ صندلی تاشو قابل‌حمل☐ توالت فرنگی سیار☐

لطفا مواردی را که برای انجام آن‌ها معمولا نیاز به کمک فرد دیگری دارید، مشخص کنید:

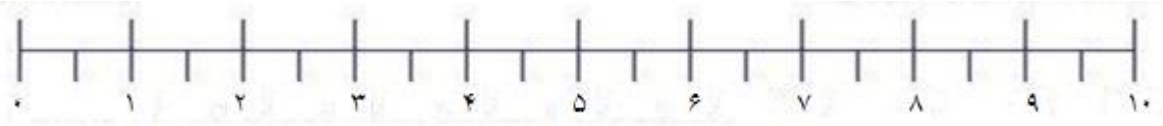
لباس‌پوشیدن و شانه زدن☐ بلند شدن☐ خوردن☐ راه رفتن☐ بهداشت فردی☐ گرفتن☐ چنگ‌زدن☐ انجام فعالیت‌های روزانه☐

آیا درد این بیماری تاثیری روی شما گذاشته‌است یا خیر؟

طی هفته گذشته چقدر درد به خاطر بیماریتان داشته‌اید (لطفا با رسم یک خط عمود روی نوار زیر، شدت درد خودتان را نشان دهید)؟



با در نظر گرفتن تمامی تاثیرات بیماری آرتریت روماتوئید روی شما، با رسم یک خط عمود روی نوار زیر، وضعیت سلامتی خودتان را نشان دهید.



اینجانب..... در کمال اختیار، رضایت کامل خود را مبنی بر شرکت در این پژوهش رجیستری و Follow up های بعدی به عنوان نمونه داوطلب اعلام می‌دارم.

نام و نام خانوادگی نمونه داوطلب

امضا/اثر انگشت با تاریخ

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RHEUMATRY RA FOLLOW-UP QUESTIONNAIRE

DEMOGRAPHIC INFORMATION:

National Code*:	**Date*:**	**Physician Name:**
Hospital Document ID:	**Rheumatry ID:**	
First Name (EN)*:	**Last Name (EN)*:**	
Full Name in Local Language*:		

Address Type: Urban☐ Rural☐
Province: ---------- **City:** ----------
Address: ----------
Phone number*: ---------- **Mobile*:** ----------
E-mail address: ----------

PERSONAL HISTORY:

Smoking (1 Pipe = 2.5 Cigarettes)**:**

Non Smoker ☐	**Smoker** ☐	
Passive Smoker ☐	**Former** ☐ Date of Start: ---------- Date of Quit: ---------- Cigarettes/Day:----------	**Current** ☐ Date of Start: ---------- Cigarettes/Day:----------

Bubble Hubble: No☐ Yes☐
Alcohol: No ☐ Yes☐ **If yes:** Daily☐ 1-3/Week☐ 1-4/Month☐ Infrequently☐
Type: ---------- **Volume:** --------- **No. of Units:** ----------
(A unit of alcohol is equivalent to a standard glass of beer (285ml), a single measure of spirits (30ml), a medium-sized glass of wine (120ml), or 1 measure of an aperitif (60ml)).
Illicit Drugs: No☐ Yes☐ **If yes:** Opium☐ Hash☐ Chrystal Meth☐ Heroin☐ Cocaine☐ Marijuana☐ Methadone☐ Other: ----------
Allergy to Drugs: No☐ Yes☐ **Drug(s) Name:** ----------
Bone Fracture History: No☐ Yes☐ **Location:** ---------- **Comment:** ----------
Poor Compliance to Medication: No☐ Yes☐

Overlap Syndrome: No☐ Yes☐ **If yes please mark it:**

Type	No/Yes	Date	Type	No/Yes	Date
Antiphospholipid Syndrome	No☐ Yes☐		Seronegative Arthropathy	No☐ Yes☐	
Scleroderma	No☐ Yes☐		Vasculitis	No☐ Yes☐	
Systemic Lupus Erythematosus	No☐ Yes☐		Behcet Disease	No☐ Yes☐	
Sjogren	No☐ Yes☐		Hypothyroidism	No☐ Yes☐	
Polymyositis	No☐ Yes☐		Dermatomyosis	No☐ Yes☐	
Diabetes Mellitus	No☐ Yes☐		Hyperthyroidism	No☐ Yes☐	
MCTD	No☐ Yes☐		Multiple Sclerosis	No☐ Yes☐	
Ankylosing Spondylitis	No☐ Yes☐		Other:		

Pregnancy: No☐ Yes☐

Are You Pregnant? No☐ Yes☐
Number of Pregnancy: --------- **Age of First Pregnancy:** ---------- **Age of Second Pregnancy:** ---------- **Age of Third Pregnancy:** ----------
Number of Children: ----------
Fetal Loss: No☐ Yes☐ **If yes, Number of Fetal Loss:** ----------
Premature Infants: No☐ Yes☐ **If yes, Number of Premature Infants:** ----------

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Contraception Method: Natural□ OCP□ IUD□ Other: ----------
Was your first pregnancy after RA onset? No□ Yes□
Pregnancy during your RA course: No□ Yes□
Effect of pregnancy on your RA disease in **first** trimester: Improved□ Remission□ Persistent□ Flare□
Effect of pregnancy on your RA disease in **second** trimester: Improved□ Remission□ Persistent□ Flare□
Effect of pregnancy on your RA disease in **third** trimester: Improved□ Remission□ Persistent□ Flare□
Postpartum Flare: No□ Yes□ **If yes:** Before three months□ After three months□

COMORBIDITY: No□ Yes□ **If yes please mark it:**

Category	Abnormality	No/Yes	Date of Onset	Category	Abnormality	No/Yes	Date of Onset
Metabolic (Endocrine) Disorder	Amenorrhea	No□ Yes□		**GI**	Fatty Liver	No□ Yes□	
	Hypercholesterolemia	No□ Yes□			Peptic Ulcer	No□ Yes□	
	Hypertriglyceridemia	No□ Yes□			IBD	No□ Yes□	
	Diabetes Insipidus	No□ Yes□			IBS	No□ Yes□	
	Hyperthyroidism	No□ Yes□			Viral Hepatitis	No□ Yes□	
	Hypothyroidism	No□ Yes□			Other		
	Subacute Thyroiditis	No□ Yes□		**Respiratory**	Asthma	No□ Yes□	
	Cushingoid Appearance	No□ Yes□			Allergy	No□ Yes□	
	Diabetes	No□ Yes□			COPD	No□ Yes□	
	Hypogonadism	No□ Yes□			Bronchiectasis	No□ Yes□	
	Hypergonadism	No□ Yes□			TB	No□ Yes□	
	Other				ILD	No□ Yes□	
Cardiac (CAD)	CHF	No□ Yes□			PTE	No□ Yes□	
	Hypertension	No□ Yes□			Pneumonia	No□ Yes□	
	IHD	No□ Yes□			Other		
	IHD- CABG	No□ Yes□		**Eye**	Cataract	No□ Yes□	
	IHD- MI	No□ Yes□			Glaucoma	No□ Yes□	
	IHD- Stent	No□ Yes□			Conjunctivitis	No□ Yes□	
	Other				Other		
Bone and Muscle	Osteoporosis	No□ Yes□		**Skin**	Pyoderma	No□ Yes□	
	OA	No□ Yes□			Erythema Nodosum	No□ Yes□	
	Myopathy	No□ Yes□			Hives	No□ Yes□	
	Aseptic Necrosis	No□ Yes□			Seborrheic Dermatitis	No□ Yes□	
	Osteomyelitis	No□ Yes□			Other		
	Vitamin D Deficiency	No□ Yes□		**CNS**	CVA	No□ Yes□	
	Septic Arthritis	No□ Yes□			Optic Neuritis	No□ Yes□	
	Other				MS	No□ Yes□	
Hematologic	Anemia	No□ Yes□			NMO	No□ Yes□	
	Transfusion	No□ Yes□			Epilepsy	No□ Yes□	
	Felty Syndrome	No□ Yes□			Other		
	Other			**Congenital Disorder**	No□ Yes □ **If yes,** Type: ----------		
Malignancy	No□ Yes □ **If yes,** Type: ----------						

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FAMILIAL HISTORY: No☐ Yes☐ **If yes please mark it:**

Disease	Mother	Father	Brother	Sister	Son	Daughter	Grand Mother		Grand Father		Aunt		Uncle		Niece	Nephew	Grand Child		Other
							Maternal	Paternal	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal			Son	Daughter	
Rheumatic Diseases																			
RA																			
Sjogren																			
SLE																			
APS																			
AS																			
SpA																			
Reactive RA																			
Scleroderma																			
MCTD																			
Behcet's Disease																			
Vasculitis																			
Gout																			
PM																			
DM																			
Undifferentiated Arthritis																			
Non-Rheumatic Diseases																			
OA																			
OP																			
IBD																			
Hyperthyroidism																			
Hypothyroidism																			
Multiple Sclerosis																			
Type 1 Diabetes																			
Type 2 Diabetes																			
Atherosclerosis(Male< 60 Y and Female<50 Y)																			
Celiac Disease																			
Vitiligo																			
Primary HTN																			
Secondary HTN																			
Other																			

Twin: No☐ Yes☐
If Yes: Monozygotic☐ Dizygotic, Brother☐ Dizygotic, Sister☐
Does your twin Brother/Sister have autoimmune disease? No☐ Yes☐ **If yes, Type:** ----------

Consanguineous Marriage: No☐ Yes☐
If yes: Father and Mother ☐ Grandfather and Grandmother ☐ Patient and Spouse ☐
(First Degree☐ Second Degree☐) (First Degree☐ Second Degree☐) (First Degree☐ Second Degree☐)

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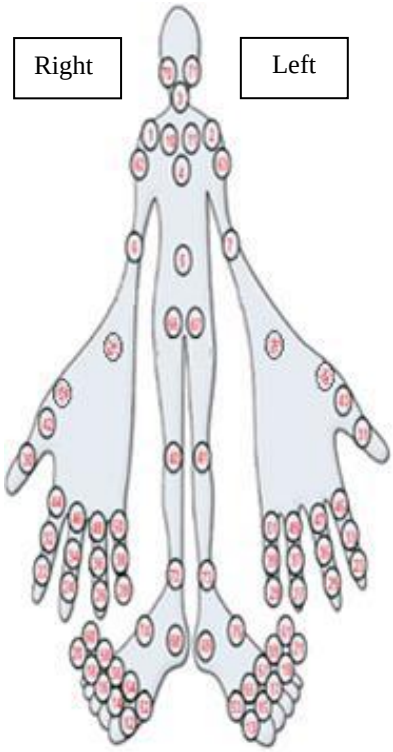
SURGERY / INJECTION:

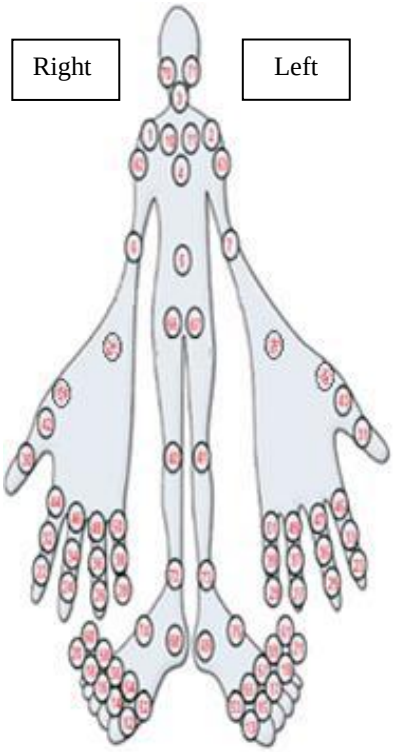
Surgery: No☐ Yes☐

Corticosteroid Injection: No☐ Yes☐

Right Left



Right Left



Surgery:

Type		Date	Remark
Articular Surgery	Joint Replacement		
	Arthroscopy		
	Synovectomy		
	Arthrodesis		
	Lavage		
	Other		
Periarticular Surgery	Carpal Tunnel Syndrome		
	Tenosynovectomy		
	Tendon Repair		
	Other		

Corticosteroid Injection:

Location		Date	Remark
Articular			
Periarticular	Ganglion		
	Baker Cyst		
	Other		

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PAST DRUG HISTORY:

Row	Generic Name	Trademark Name	X (X= Number of Drug for Each Time)	Y & Z (Y= How Many Times Per Z Days)	Strength	Start Date	Stop Date	Reason to Stop								Remark
								No Response	Pregnancy	Infection	Surgery	No Compliance	According to Physician Comment	Adverse Effect *	Other	
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
11																
12																
13																
14																
15																
16																
17																
18																
19																
20																
21																
22																
23																
24																

***Physicians or registrars should ask about the adverse effect type and the severity of adverse effect according to Rheumatry registry website, Past Medical History part.**

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PRESENT MEDICATION:

Row	Generic Name	Trademark Name	X (X= Number of Drug for Each Time)	Y & Z (Y= How Many Times Per Z Days)	Strength	Start Date	Remark
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

CLINICAL EVALUATION:

Pattern: Mono□ Oligo□ Polyarticular□(Symmetrical□ Asymmetrical□) Palindromic□ Other: --------

If Polyarticular: Additive□ Migratory□ Intermittent□

Relapse Course Duration: ---------- (Weeks)

PHYSICAL EXAMINATION AND REVIEW OF SYSTEMS:

Physical Examination:

Temp: --------- **Pulse:** --------

Blood Pressure (Right) (mmHg): --------- **Blood Pressure (Left) (mmHg):** --------

Height: -------- **(cm)** **Weight:** --------- **(kg)** **BMI:** ----------

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Constitutional	Fever□ Weight Loss (10% Weight During 6 Months)□ (If yes: -----kg/month), Anorexia□ Fatigue□ Malaise□ Night Sweat□ Other ----------
Eye	Episcleritis□ Scleritis□ Iridocyclitis□ Anterior Uveitis□ Post Uveitis□ Dryness□ Vasculitis□ Scleromalacia□ Keratoconjunctivitis Sicca□ Redness□ Itching□ Pain□ Blurred Vision□ Conjunctivitis□ Visual Loss□ Double Vision□ Icteric□ Lacrimation□ Other ----------
Ear-Nose-Mouth-Throat	Dryness in Mouth□ Loss of Hearing□ Bleeding□ Sore Throat□ Hoarseness□ Periodontitis□ Ulcer□ Gingivitis□ Ear Discharge□ Thyromegaly□ Post-Nasal Discharge□ Nasal Polyp□ Tinnitus□ Olfactory Disorder□ Other ----------
Skin	Rheumatoid Nodule□ Petechia□ Purpura□ Hair Loss□ Splinter Hemorrhage□ Nail Pitting□ Nail Fungal□ Periungual Erythema□ Ulcer□ Hyperpigmentation□ Hypopigmentation□ Raynaud□ Photosensitivity□ Alopecia□ Livedo Reticularis□ Papule□ Macule□ Clubbing□ Easy Bruising□ Other ----------
Cardiovascular	Chest Pain□ Pericardial Effusion□ Endocarditis□ Palpitation□ Souffle□ Varicose□ Arrhythmia□ CHF□ CABG□ Stent□ Syncope□ Cyanosis□ Other ----------
Lung	Dyspnea□ Pleural Effusion□ Sputum□ Hemoptysis□ Nodule□ RA-ILD□ Cough□ Wheezing□ Crackle□ Other ----------
Gastrointestinal	Abdominal Pain□ Nausea□ Vomiting□ Heart Burn□ Dysphagia□ Odynophagia□ Diarrhea□ Constipation□ Hepatomegaly□ Splenomegaly□ Hemorrhoids□ Melena□ Tenderness□ Ascites□ Anorexia□ Other ----------
Neurological/ Psychiatric	Carpal Tunnel Syndrome□ Paresthesia□ Seizures□ Mood Disorder□ Headache□ Insomnia□ Dizziness□ Muscle Spasm□ Memory Loss□ Agitation□ Numbness□ Tremor□ Drowsiness□ Central Neuropathy□ Cranial Neuropathy□ Peripheral Neuropathy□ Snoring□ Other ----------
Musculoskeletal	Weakness□ Joint Pain□ Osteoarthritis□ Muscle Pain□ Pitting Edema□ DVT□ Amputation□ Low Back Pain□ Sarcopenia□ Atrophy□ Other ----------
Hematologic/ Lymph Node	Lymphadenopathy□ Anemia□ Other ----------
Renal	Glomerulonephritis□ Interstitial Nephritis□ Renal Tubular Nephritis□ Renal Stone□ Acute Kidney Failure□ Chronic Kidney Failure□ Polycystic Kidney Disease□ Uremia□ Amyloidosis□ ESRD□ Other ----------
Genitourinary	Dysuria□ Frequency□ Hematuria□ Discharge□ Ulcer□ Impotency□ Vaginal Dryness□ Infertility□ Menorrhagia□ UTI□ Other ----------
	Menopause: No□ Yes□ If yes date: ----------
	Menses: Regular□ Irregular □ Other ----------
Breast	Pain□ Nipple Discharge□ Mass□ Other ----------

Muscle Force Score:

	Location			**Score (1-5)**
Weakness	Upper Limb	Proximal	Right	
			Left	
		Distal	Right	
			Left	
	Lower Limb	Proximal	Right	
			Left	
		Distal	Right	
			Left	

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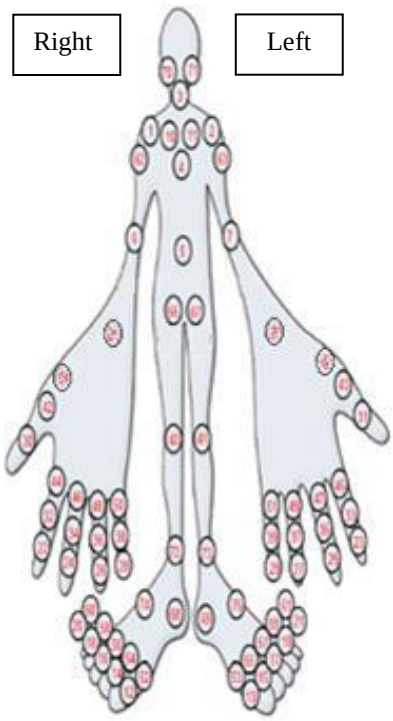
JOINT EVALUATION: No☐ Yes☐

If yes please mark the severity of Swelling, Tenderness and Limitation from 1 to 4 plus

Swelling Count

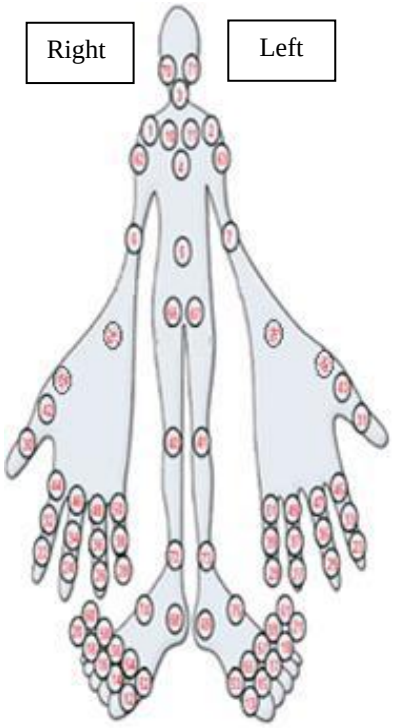
Right Left



Total Swelling Joints: ---------

Pain Tenderness Count

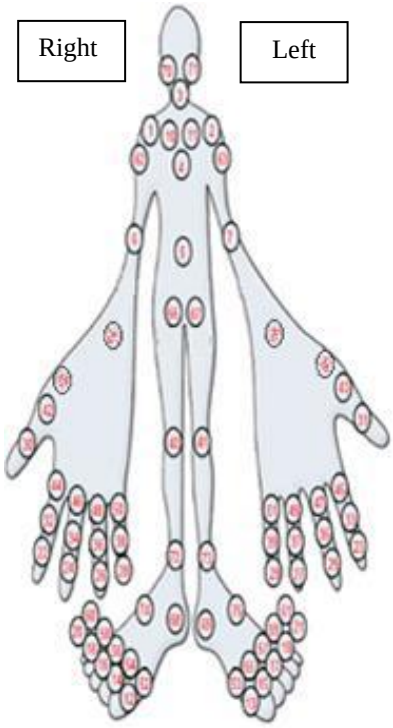
Right Left



Total Painful Joints: ---------

Limitation

Right Left



SKELETAL DEFORMITIES: No☐ Yes☐ If yes please mark it:

Deformity	No/Yes	Right	Left	Remark
Ulnar Deviation	No☐ Yes ☐			
Z Deformity	No☐ Yes ☐			
Flesam Knee	No☐ Yes ☐			
Flesam Elbow	No☐ Yes ☐			
Piano Key Styloid	No☐ Yes ☐			
Boutonniere	No☐ Yes ☐			
Swan Neck	No☐ Yes ☐			
Subluxation (MCP)	No☐ Yes ☐			
Subluxation (Wrist)	No☐ Yes ☐			
Genu Valgus	No☐ Yes ☐			
Genu Varus	No☐ Yes ☐			
Hallux Rigidus	No☐ Yes ☐			
Hallux Valgus	No☐ Yes ☐			
Over Ridding	No☐ Yes ☐			
Heberden Node	No☐ Yes ☐			
Bouchard Node	No☐ Yes ☐			
Hypertrophic Malleolar	No☐ Yes ☐			
Kyphosis	No☐ Yes ☐	-		
Scoliosis	No☐ Yes ☐	-		

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LABORATORY MEASUREMENTS:

Category	Lab Tests	Result	Range	Unit	Interpretation			
					Low	Normal	High (+/++/+++)	Pos/Neg
Hematology and Coagulation	WBC							
	Lymphocyte							
	Neutrophil							
	Eosinophil							
	Basophil							
	RBC							
	Retic							
	Hb							
	HCT							
	MCV							
	Plt							
	ESR							
	PT							
	PTT							
	INR							
Biochemistry	FBS							
	TG							
	Cholesterol							
	HDL							
	LDL							
	BUN							
	Cr							
	Uric Acid							
	AST							
	ALT							
	ALP							
	CPK							
	LDH							
	Albumin							
	Iron							
Serology	CRP							
	PPD							
	Wright							
	Coombs Wright							
	Widal							
	2ME							

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	RF							
Immunology	Anti-CCP							
	FANA							
	ANA							
	Anti-dsDNA							
	Anti-MCV							
	C3							
	C4							
	CH50							
	TSH							
	T3							
	T4							
	Anti-TPO							
	Ferritin							
	PTH							
	Procalcitonin							
	IGRA							
Viral	Hbs-Ag							
	HBV-Ab							
	HCV-Ab							
	HIV-Ab							
Elec and Vitamin	Ca							
	P							
	25OH-VitD (ng)							
Genetic	HLA-B27							
Urine Analysis	RBC							
	WBC							
	Granular Cast							
	RBC Dysmorphic							
	Urine Protein (+)							
	Urine Blood (+)							
	pH							
	Specific Gravity							
	Culture (+/-)							
24 Hours Urine Analysis	Volume							
	Protein							
	Cr							
	Ca							
	P							

Laboratory Name: ---------- Laboratory City: ----------
Date: ----------

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DIAGNOSIS CRITERIA (ACR CLASSIFICATION)*:

2010 ACR / EULAR Rheumatoid Arthritis Classification Criteria

A. Joint Involvement	**Date of Onset**	**Point Score**
1 large joint		0
2−10 large joints		1
1−3 small joints (with or without involvement of large joints)		2
4−10 small joints (with or without involvement of large joints)		3
>10 joints (at least one small joint)		5
B. Serology (at least 1 test result is needed for classification)		
Negative RF *and* negative ACPA		0
Low-positive RF *or* low-positive ACPA		2
High-positive RF *or* high-positive ACPA		3
C. Acute-Phase Reactants (at least one test result is needed for classification)		
Normal CRP *and* normal ESR		0
Abnormal CRP *or* abnormal ESR		1
D. Duration of Symptoms		
<6 weeks		0
≥6 weeks		1

Definite RA ≥6 scores

1987ACR Rheumatoid Arthritis Classification Criteria

Items	**Date of Onset**	**Point Score**
Morning stiffness		1
Arthritis of three or more joint areas		1
Hand joint involvement		1
Symmetric arthritis		1
Rheumatoid nodules		1
Serum rheumatoid factor positive		1
Radiographic changes		1

Definite RA ≥4 points

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Persian version of the Stanford Health Assessment Questionnaire (HAQ) in patients with rheumatoid arthritis: No□ Yes□ **If yes please mark it:**

Row	Dressing: Are you able to:	Without any difficulty	With some difficulty	With much difficulty	Unable
1	Dress yourself, including shoelaces and buttons?	□	□	□	□
2	Shampoo your hair?	□	□	□	□
	Arising: Are you able to:				
3	Stand up from a straight chair?	□	□	□	□
4	Get up and down from Iranian style futon (a mattress on the floor)?	□	□	□	□
	Eating: Are you able to:				
5	Use spoons and forks?	□	□	□	□
6	Lift a full cup or glass to your mouth?	□	□	□	□
7	Open a new milk carton?	□	□	□	□
	Walking: Are you able to:				
8	Walk outdoors on flat ground?	□	□	□	□
9	Climb up five steps?	□	□	□	□
	Hygiene: Are you able to:				
10	Wash and dry your body?	□	□	□	□
11	Take a tub bath?	□	□	□	□
12	Go to a squat toilet by yourself?	□	□	□	□
	Reach: Are you able to:				
13	Reach and get down a 2.5 kg nylon pocket from just above your head?	□	□	□	□
14	Bend down to pick up clothing from the floor?	□	□	□	□
	Grip: Are you able to:				
15	Open car doors?	□	□	□	□
16	Open previously opened jars?	□	□	□	□
17	Turn faucets on and off?	□	□	□	□
	Activities: Are you able to:				
18	Run errands and shop?	□	□	□	□
19	Get in and out of a car?	□	□	□	□
20	Praying from the standing position (Kneeling)?	□	□	□	□

Please check any AIDS or DEVICES that the patient usually uses for any of these activities:
Cane□ Walker□ Crutches□ Wheelchair□ Special Built up Chair□ Raised Toilet Seat□

Categories for which the patient need HELP from another person:
Dressing and Grooming□ Arising□ Eating□ Walking□ Hygiene□ Reach□ Grip□ Activities□

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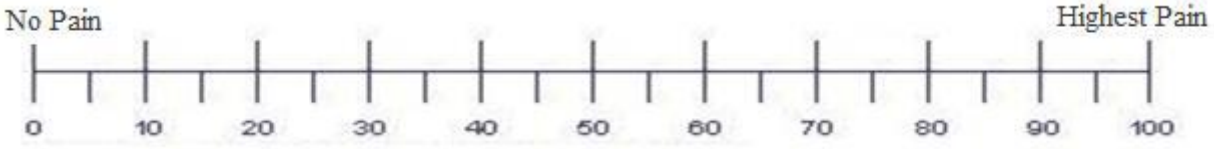
DISEASE ACTIVITY SCORE (DAS-28)

CRP: **ESR:**

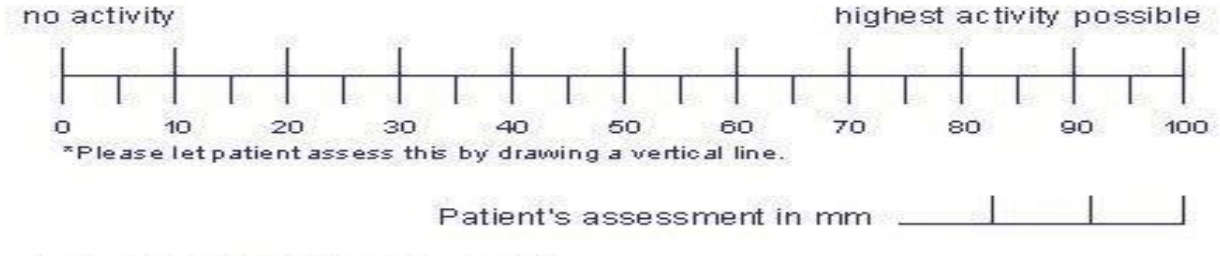
Pain Visual Analog Scale (VAS):

How was your pain in last 7 days?



Patient Global Assessment:

Considering all the effects of rheumatoid arthritis on you, show your health status by drawing a vertical line on the strip below:



PHYSICIAN GLOBAL ASSESSMENT:

Early Morning Stiffness: ---------- Minutes

Grip Strength (kg): RT: ---------- **LT:** ---------- **Fatigue:** ----------

Sleep: Normal☐ Disturbed☐ Excess☐ Mild Loss☐ Severe Loss☐

EYE EXAMINATION FOR ANTIMALARIAL DRUGS:

Vision	Left: --------- Right: ---------
Cornea	Punctate to Linear Opacities☐ Vortex Keratopathy☐ Bull's Eye☐
Retina	Atrophy☐ Abnormal Pigmentation☐ Loss of Foveal Reflex☐
Remark	Continue Antimalarial Drugs☐ Lower Dose of Antimalarial Drugs☐ Discontinue Antimalarial Drugs☐

Comment: ----------

---------- **Date:** ----------

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PARACLINIC EXAMINATION:

X-RAY AND IMAGING: No☐ Yes☐

Region	Subtype					Remark
	Osteophyte	Reduced Joint Space	Erosion	Ankylosis	Subluxation	
Wrist (Right)						
Wrist (Left)						
MCP (Right)						
MCP (Left)						
PIP (Right Hand)						
PIP (Left Hand)						
DIP (Right)						
DIP (Left)						
Elbow (Right)						
Elbow (Left)						
Shoulder (Right)						
Shoulder (Left)						
Neck						
Lumbar						
Sacroiliac (Right)						
Sacroiliac (Left)						
Knee (Right)						
Knee (Left)						
Ankle (Right)						
Ankle (Left)						
Hip (Right)						
Hip (Left)						
MTP (Right)						
MTP (Left)						
PIP (Right Foot)						
PIP (Left Foot)						
TM Joint (Right)						
TM Joint (Left)						

Comment: ----------

---------- **Date:** ----------

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BONE MINERAL DENSITY: No☐ Yes☐

Location	Date	T-Score	Z-Score	BMD (g/cm^2)
Femur Total				
Femur Neck				
Lumbar Spine (L1-L4)				
Lumbar Spine (L2-L4)				
1/3 Distal of the Radius				
TBS		Score:		

Device: Hologic☐ Lunar☐ Norland☐ Medilink☐ Other: ---------- **Date:** --------- **Place:** ---------

PULMONARY FUNCTION TEST: No☐ Yes☐

PFT	Actual	Predicted (%)
FEV1		
FVC		
FEV1/FVC		
MEF25-75		
MEFR		
Body Box	**Actual**	**Predicted (%)**
FEV1		
FVC		
FEV1/FVC		
MEF25-75		
TLC		
Raw		
SRaw		
TGV		
RV		
RV/TLC		
DLCO	**Actual**	**Predicted (%)**
TLC		
DLCO		
KCO		

Result: ----------

Specialist: ---------- **Date:** ----------

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CHEST CT-SCAN: No□ Yes□

Abnormality	No/Yes	Date of Onset	Remark
Lymphadenopathy	No□ Yes□		
Mass in Lung	No□ Yes□		
Nodule	No□ Yes□		
Pleural Effusion	No□ Yes□		Size: ---------- Unilateral □ Bilateral □
Pleural Thickening	No□ Yes□		
Shrinking Lung	No□ Yes□		
Pleural Fibrosis	No□ Yes□		
Pulmonary Infarction	No□ Yes□		
Calcification	No□ Yes□		
Bronchiectasia Tractional	No□ Yes□		
ILD	No□ Yes□		--------- % Reticular Pattern □ Bronchiectasia □ Honeycomb □
Ground Glass	No□ Yes□		≥20%□ <20%□
Alveolitis	No□ Yes□		Grade I□ II□ III□
Honeycombing	No□ Yes□		
Fibrotic Change	No□ Yes□		
Esophageal Dilatation	No□ Yes□		
Pneumonitis	No□ Yes□		

Pathology Result: ----------

---.

Specialist: ---------- **Date:** ---------- **PAX Number:** ---------- **Place:** ----------

Abdomen and Pelvis Ultrasound/ Sonography: No□ Yes□

Result: ----------

Date: ----------.

MRI: No□ Yes□

Result: ----------

---.

Date: ----------.

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ANGIOGRAPHY: No□ Yes□

Vessel Involvement	
Left Main	-------%
LAD	-------%
LCX	-------%
RCA	-------%
Result:	1 Vessel □ 2 Vessel □ 3 Vessel □
Plan	Medical Treatment PCI: 1 Vessel □ 2 Vessel □ CABG
Rt Cath	Systolic Pressure: -------- Diastolic Pressure: ------- Mean Pressure: --------
RA Pressure	
RV Pressure	
Aortic Pressure	
LVEDP	
P.C.W.P (Pulmonary Capillary Wedge Pressure)	
Cardiac Output	
Other	

Angiography Result: ----------

Specialist: ----------**Date:** ----------**Place:** ----------

PHYSICIAN COMMENT:

Chief Complaint: ----------

Disease Course: ----------

Overall Comment: Complete Remission□ Partial Remission□ Recurrent□ Flare□

Physician Name: **Signature:**

Registrar Name: **Signature:**

Lab Samples: DNA□ RNA□ Serum□

Next Visit Date:

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پرسشنامه Stanford (HAQ) فارسی

لطفا پاسخ‌هایی را که توانایی معمول شما را در هفته گذشته به بهترین شکل نشان می‌دهند، انتخاب کنید:

شماره	لباس پوشیدن: آیا شما می‌توانید:	بدون هیچ‌گونه مشکل	با کمی مشکل	با سختی زیاد	نمی‌توانم
۱	لباس‌هایتان را بپوشید، بند کفش‌ها و دگمه‌های لباس‌هایتان را ببندید؟	☐	☐	☐	☐
۲	موهای خود را بشویید؟	☐	☐	☐	☐
	بلند شدن: آیا شما می‌توانید:				
۳	از یک صندلی بدون دسته بلند شوید؟	☐	☐	☐	☐
٤	به تختخواب (یا رختخواب) بروید یا از آن بلند شوید؟	☐	☐	☐	☐
	خوردن: آیا شما می‌توانید:				
٥	از قاشق و چنگال به راحتی استفاده کنید؟	☐	☐	☐	☐
٦	یک لیوان یا استکان پر را تا دهان بالا ببرید؟	☐	☐	☐	☐
۷	یک بطری آب معدنی را باز کنید؟	☐	☐	☐	☐
	راه رفتن: آیا شما می‌توانید:				
۸	در بیرون از منزل بر روی یک سطح صاف پیاده‌روی کنید؟	☐	☐	☐	☐
۹	از ٥ پله بالا بروید؟	☐	☐	☐	☐
	بهداشت فردی: آیا شما می‌توانید:				
۱۰	کل بدن خود را بشویید و خشک کنید؟	☐	☐	☐	☐
۱۱	حمام بکنید (یا دوش بگیرید)؟	☐	☐	☐	☐
۱۲	بدون نیاز به کمک از دستشویی ایرانی استفاده کنید؟	☐	☐	☐	☐
	گرفتن: آیا شما می‌توانید:				
۱۳	بسته‌ای مانند یک کیسه نایلون ۲/٥ کیلویی را بگیرید و از بالای سر آن را روی زمین بگذارید؟	☐	☐	☐	☐
١٤	خم شوید و لباس خود را از روی زمین بردارید؟	☐	☐	☐	☐
	چنگ زدن: آیا شما می‌توانید:				
١٥	درب ماشین را باز کنید؟	☐	☐	☐	☐
١٦	در مربایی را که قبلا یکبار باز شده، دوباره باز کنید؟	☐	☐	☐	☐
۱۷	شیر آب را باز و بسته کنید؟	☐	☐	☐	☐
	فعالیت‌های دیگر: آیا شما می‌توانید:				
۱۸	بیرون بروید و کار خرید را انجام دهید؟	☐	☐	☐	☐
۱۹	سوار ماشین شوید و از ماشین پیاده شوید؟	☐	☐	☐	☐
۲۰	نماز را ایستاده بخوانید؟	☐	☐	☐	☐

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لطفا هر کدام از وسایلی را که معمولا برای انجام فعالیت‌های یاد شده استفاده می‌کنید، علامت بزنید:

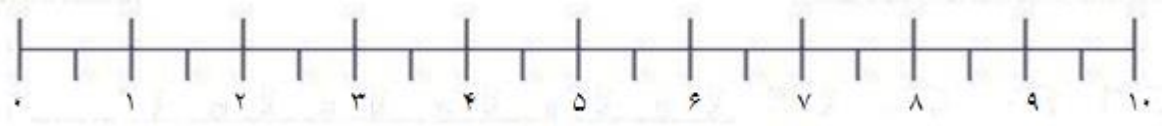
عصا☐ حفاظ پیاده‌روی☐ عصای آتل‌دار☐ صندلی چرخدار☐ صندلی تاشو قابل‌حمل☐ توالت فرنگی سیار☐

لطفا مواردی را که برای انجام آن‌ها معمولا نیاز به کمک فرد دیگری دارید، مشخص کنید:

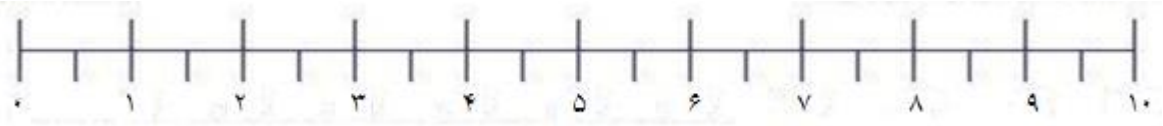
لباس‌پوشیدن و شانه زدن☐ بلند شدن☐ خوردن☐ راه رفتن☐ بهداشت فردی☐ گرفتن☐ چنگ‌زدن☐ انجام فعالیت‌های روزانه☐

آیا درد این بیماری تاثیری روی شما گذاشته‌است یا خیر؟

طی هفته گذشته چقدر درد به خاطر بیماریتان داشته‌اید (لطفا با رسم یک خط عمود روی نوار زیر، شدت درد خودتان را نشان دهید)؟



با در نظر گرفتن تمامی تاثیرات بیماری آرتریت روماتوئید روی شما، با رسم یک خط عمود روی نوار زیر، وضعیت سلامتی خودتان را نشان دهید.



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