AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

(Patient Label)

Patient Name_____

Date of Visit_____

RHEUMATOID ARTHRITIS

- This template has been built for reference purposes and its elements may be adopted as per the discretion of the provider or practice into their electronic health record (EHR).
- You are free and encouraged to document information anywhere in your EHR and personal template based on workflow preferences.

CHIEF COMPLAINT: _____

AGE: _____ **GENDER:** _____

VISIT DIAGNOSIS: _____

RHEUMATOID ARTHRITIS HISTORY:

Diagnosed with Rheumatoid Arthritis in (MM/YY) _____

Disease characteristics:

	Present	Absent	Description
Rheumatoid factor			
ACPA/CCP			
Erosive Arthritis			
Extraarticular Disease			

Family History:
Family History of Rheumatoid Arthritis? □ Y/ □N
Family History of Other Rheumatologic Disease (Specify): _____

PREVIOUS MEDICATION THERAPY FOR RHEUMATOID ARTHRITIS:

Medication name	Dose	Frequency	Dates of use	Reason for discontinuation

CURRENT VISIT:

Subjective:

Interim Events:

Hospitalization: □ Y/ □N

Social History:

Current Medications: _____

Allergies: _____

Physical Exam:

Vitals: BMI:

Detailed Exam:

Assessment Scores:

Patient's global assessment of arthritis (0-10):

Tender joints #:

Swollen joints #:

Physician's global assessment of arthritis (0-10):

Please choose one of the following disease activity assessments.

Disease Activity Instrument	Date	Score	Range
CDAI			
SDAI			
DAS28-ESR			
DAS28-CRP			

Please choose one of the following patient reported outcomes.

PRO Instrument	Date	Score	Range
PROMIS Fatigue			
PROMIS Physical Function			
HAQ-II			
Rapid 3			

Laboratory Results:

{May be pulled from the lab results section of the EMR including the latest: CBC with differential, BUN, Cr, LFTs, ESR, CRP, Lipids, RF, CCP, ANA, dsDNA, Sm, RNP, SSA, SSB, Scl70, Jo1, etc.}

Infectious Diseases Screening:

Test Name	Positive	Negative	Result	Date
Hepatitis B sAg	□	□		
Hepatitis B sAb	□	□		
Hepatitis B cAb	□	□		
Hepatitis C Ab	□	□		
PPD	□	□		
Quantiferon Gold	□	□		
Tb spot	□	□		

Imaging:

Assessment:

(Patient's name) is a (age) year old (gender) with a history of rheumatoid arthritis. The patient has/has not achieved clinical remission.

Plan:

Immunizations:

Immunization	Yes	No	Date(s)
Influenza	☐	☐	
Prevnar	☐	☐	
Pneumovax	☐	☐	
Zostavax	☐	☐	
Shingrix	☐	☐	
Hepatitis B series	☐	☐	
Other:	☐	☐	

Healthcare maintenance plan

Medication monitoring	**Yes**	**No**	**Result**	**Date**
Hydroxychloroquine or chloroquine eye exam	☐	☐		
Bone Health				
DXA screening	☐	☐		
Fertility and Contraception				
Sexually active	☐	☐		
Counseling performed	☐	☐		
Contraception Plan	☐	☐		
Planning to have children	☐	☐		
Cardiovascular health				
LDL	☐	☐		

Return to clinic in:

Physician signature: _____ Date: _____