

|                     |
|---------------------|
| (Patient Label)     |
| Patient Name _____  |
| Date of Visit _____ |

### PSORIATIC 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:** \_\_\_\_\_

**PSORIATIC ARTHRITIS HISTORY:**

Diagnosed with Psoriasis in (YYYY) \_\_\_\_\_

Diagnosed with Psoriatic Arthritis in (YYYY) \_\_\_\_\_

**Disease characteristics and associated conditions documented at this visit or any prior visit:**

|   | Present                  | Absent                   | Not Assessed             |
|---|--------------------------|--------------------------|--------------------------|
| Peripheral Arthritis                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dactylitis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Enthesitis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriatic nail pitting or onycholysis on exam     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Uveitis*  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflammatory Bowel Disease*                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sacroiliitis (on X-ray or MRI)                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inflammatory back pain                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Periostitis or Erosions on X-ray of hands or feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

\*Uveitis diagnosed by an ophthalmologist. IBD diagnosed by a gastroenterologist.

**Family History:**

Family History of Psoriasis?  Y/  N

Family History of Psoriatic Arthritis?  Y/  N

Family History of Ankylosing spondylitis?  Y/  N

Family History of Inflammatory Bowel Disease?  Y/  N

Family History of Other Rheumatologic Disease (Specify): \_\_\_\_\_

**PREVIOUS MEDICATION THERAPY FOR PSORIATIC ARTHRITIS:**

| Medication name | Dates of use | Reason for discontinuation |                          |                          |       |
|-----------------|--------------|----------------------------|--------------------------|--------------------------|-------|
|                 |              | Primary non-responder      | Lost response            | Adverse event            | Other |
|                 |              | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |       |
|                 |              | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |       |
|                 |              | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> |       |

**CURRENT VISIT:**

**Subjective:**

**Interim Events:**

Hospitalization:  Y /  N

**Important comorbidities:**

Hypertension  Y /  N

Diabetes mellitus  Y /  N

Most recent hemoglobin A1C \_\_\_\_\_

Hyperlipidemia  Y /  N

Most recent triglyceride level \_\_\_\_\_

Cardiovascular disease  Y /  N

Depression  Y /  N

Fibromyalgia  Y /  N

**Social History:**

Smoking history: pack years \_\_\_\_\_, active smoker  Y /  N

Alcohol use: standard drinks per week \_\_\_\_\_.

**Current Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Physical Exam:**

Vitals:

Weight:

Height:

Detailed Exam:

**Skin:**

Body Surface Area:  mild <3%,  moderate 3-10%, or  severe >10% (1% is equivalent to the size of the patient's palm)

**Psoriatic Nail Dystrophy\*** present?  Y/  N

\*Nail pitting or onycholysis in the finger nails. Do not include oil spots, leukonychia, or nail ridging.

**Musculoskeletal exam:** Specify denominator, eg 28, 44/46, or 66/68 joint count.

Tender joints #:

Swollen joints #:

**Enthesitis** present?  Y/  N /  Not assessed

Common locations include: lateral epicondyles, medial epicondyles, supraspinatus insertion, greater trochanter, quadriceps tendon insertion, patellar ligament, Achilles, and plantar fascia.

**Laboratory Results:**

{Labs may be pulled from the lab results section of the EMR including: CBC with differential, BUN, Cr, LFTs, ESR, CRP}

Rheumatoid Factor:  Positive /  Negative /  Not performed

ACPA/CCP:  Positive /  Negative /  Not performed

HLA B27:  Present /  Absent /  Not performed

**Infectious Diseases Screening:**

| Test Name        | Positive                 | Negative                 | Result | Not Performed            | Date |
|------------------|--------------------------|--------------------------|--------|--------------------------|------|
| Hepatitis B sAg  | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| Hepatitis B sAb  | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| Hepatitis B cAb  | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| Hepatitis C Ab   | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| PPD              | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| QuantiFERON Gold | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |
| Tb spot          | <input type="checkbox"/> | <input type="checkbox"/> |        | <input type="checkbox"/> |      |

**Imaging (hands, feet, axial):**

**DISEASE ACTIVITY INDICES**

**Physician Global Assessment:** \_\_\_\_\_

**Patient Global Assessment:** \_\_\_\_\_

**Patient pain visual analogue score (VAS):** \_\_\_\_\_

**Please choose one or more of the following patient reported outcomes (PRO).**

| PRO Instrument           | Date | Score | Range |
|--------------------------|------|-------|-------|
| PROMIS Fatigue           |      |       |       |
| PROMIS Physical Function |      |       |       |
| HAQ-DI                   |      |       |       |
| Rapid3                   |      |       |       |

**Assessment:**

(Patient's name) is a (age) year old (gender) with a history of psoriatic arthritis

**Plan:**

**Immunizations:**

| <b>Immunization</b> | <b>Yes</b>               | <b>No</b>                | <b>Date(s)</b> |
|---------------------|--------------------------|--------------------------|----------------|
| Influenza           | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Pevnar              | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Pneumovax           | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Zostavax            | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Shingrix            | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Hepatitis B series  | <input type="checkbox"/> | <input type="checkbox"/> |                |
| Other:              | <input type="checkbox"/> | <input type="checkbox"/> |                |

**Healthcare maintenance plan:**

|                                    | <b>Yes</b>               | <b>No</b>                | <b>Date(s)</b>           |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| <b>Bone Health</b>                 |                          |                          |                          |
| DXA screening                      | <input type="checkbox"/> | <b>Result</b>            | <input type="checkbox"/> |
| <b>Fertility and Contraception</b> |                          |                          |                          |
| Sexually active                    | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Counseling performed               | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Contraception Plan                 | <input type="checkbox"/> | <input type="checkbox"/> |                          |
| Planning to have children          | <input type="checkbox"/> | <input type="checkbox"/> |                          |

Return to clinic in:

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_