Rheumatologisches
Versorgungszentrum Steglitz

Ärztliche Leitung:
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Patientquestionnaire

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Partnerpraxis der
CHARITÉ

Patnr.:…….. Date:……..

First Name: Surname:

City: Adress:

Telephone: Mobile:

Email:

Job description:

Are you currently unable to work? ☐yes ☐no Are you retired? ☐yes ☐ no

Primary care physician:

Height: Weight:

Please answer the following questions:

Which persisting troubles do you have that need to be rheumatologically clarified?

Do you have to take a high dose of pain killers on an regular basis? ☐yes ☐no

Which serious conditions you diagnosed with so far; which surgeries have been performed?

What kind of medication do you take on a regular basis?

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Have you ever been to a rheumatologist?	☐yes ☐ no
If yes: What was the outcome/diagnosis? Please bring the doctor's report!	
Are there any cases of rheumatologic diseases in your family?	☐yes ☐ no
If yes: Which?	

A) Evaluation of joint pain

Have there been any joint pain/swollen joints with duration > 3 months?	☐yes ☐ no
Does the joint pain correlate with significant morning stiffness (>1 hour)?	☐yes ☐ no
Do you regularly wake up from sleep because of joint pain?	☐yes ☐ no
Are joints persistently swollen, overheated, or overly sensitive to pressure?	☐yes ☐ no
Which joints are affected?	
Have you been diagnosed with psoriasis by dermatologist?	☐yes ☐ no

B) Evaluation of back pain

Are you suffering from deep-seated back pain with an onset before your 45. birthday and with a duration of at least 3 months?	☐yes ☐ no
Are you regularly suffering from morning stiffness in your lower back which lasts for > 30 minutes?	☐yes ☐ no
Do you regularly wake up because of the back pain?	☐yes ☐ no
Does the back pain decrease with movement?	☐yes ☐ no
Has there ever been a tenacious swelling of an entire finger/toe that lasted several days without a preceding accident ("sausage finger/toe")?	☐yes ☐ no
Has an ophthalmologist ever diagnosed you with an iris inflammation/ iritis/uveitis?	☐yes ☐ no
Does one or more of the following conditions exist in your family (first or second degree relatives): Morbus bechterew, spondyloathritis, ankylosing spondylitis, psoriasis, morbus crohn, colitis ulcerosa.	☐yes ☐ no
Have you been diagnosed with a chronic-inflammatory gastroenterological disease	☐yes ☐ no

(morbus crohn/colitis ulcerosa) after a colonoscopy?	
Have you been tested positive for the genetic marker HLA-B27?	☐yes ☐ no
Have you been diagnosed with disc damage/ prolapsed intervertebral disc?	☐yes ☐ no

C) Other symptoms

When your finger get cold do they turn white like skeletal hands and afterwards either red or dark blue and start to hurt?	☐yes ☐ no
Are you suffering from agonizing dryness in your mouth or eyes?	☐yes ☐ no
Is your skin particularly photosensitive, especially in the face or on the chest area, meaning even light exposure to sunlight results in blistering and rashes?	☐yes ☐ no
Have you ever had a thrombosis?	☐yes ☐ no
Women: Have you ever had a miscarriage?	☐yes ☐ no
Women: Are you taking any contraceptives?	☐yes ☐ no
Did any recently-onset, restraining temple headaches occur?	☐yes ☐ no
Are you experiencing pain when you're chewing in the area of your chewing muscles?	☐yes ☐ no
Are there any vision disorders like sudden blindness in one eye, recurring double vision?	☐yes ☐ no
Were you diagnosed with polyneuropathy?	☐yes ☐ no
In your blood values, did your doctor find any noticeable abnormalities in one of the following parameters? ANA, Lupus antibodies, rheumatoid factor, ACPA/Citrullin-antibodies	☐yes ☐ no
Has there ever been a significant increase of the inflammation values in the lab results?	☐yes ☐ no
Did you recently lose weight unintentionally?	☐yes ☐ no
If yes: How many kilos in what period of time?	
Are you suffering from insomnia?	☐yes ☐ no
Are you often suffering from diarrhea?	☐yes ☐ no
If yes: Is there bloody defecation?	
Are you quick to shortness of breath?	☐yes ☐ no
Are you often suffering from pneumonia/ chronic sinusitis, which lead to a frequent	☐yes ☐ no

antibiotic intake?	
Are you suffering from bloody sinusitis?	☐yes ☐ no
Are there any known allergies/ hypersensitivities to certain drugs?	☐yes ☐ no
It yes: Which?	
Do you smoke?	☐yes ☐ no
If yes: for how many years?	
Have you recently been abroad (long-distance)?	☐yes ☐ no
Are there any existing malignant diseases (e.g. cancer)?	☐yes ☐ no
If yes: Which?	
Do you have any chronic infectious diseases (e.g. hepatitis, tuberculosis)?	☐yes ☐ no
If yes: Which?	
Are you working out on a regular basis?	☐yes ☐ no

Signature:

Please bring the following documents to the agreed date:

- **The completed questionnaire.**
- **Lab results; if applicable: in particular rheumatic and inflammation values**
- **Existing hospital and doctor's reports**
- **Imaging (e.g. X-Ray, MRI, CT scan) of affected joints/ body regions**