

Doctor's Visit Worksheet for Psoriatic Arthritis

This worksheet can help you prepare for consultations with your health care provider. You do not have to answer every question.

What symptoms have caused you to seek medical advice? When did they start? (Try to be specific.)

Pain Scale:

Minimal (1-2)

Moderate (3-4)

Distressing (5-6)

Intense (7-8)

Unbearable (9-10)

Functional Ability Rating:

0 5 10

Unable to Function

Fully functional

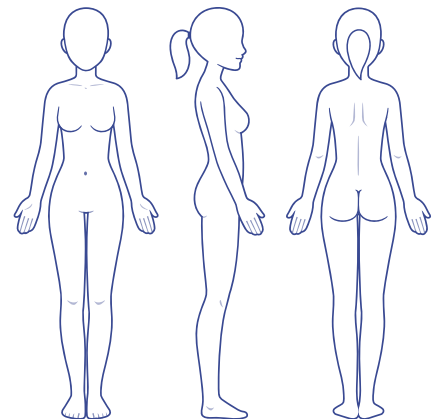
Describe the severity of your symptoms in the following situations:	Pain Level [1-10]	Functional Ability [0-10]	What do you typically do to manage the pain?
During your period			
First thing in the morning			
On an average day			
On a really difficult day			

Describe how your symptoms affect your day-to-day living (work, school, home life, activities, etc.):

The reason I am seeking time with my doctor today is:

- Gain control over symptoms
- Identify a diagnosis
- Monitor disease progression
- Get a second opinion

On the diagram to the right, circle or highlight the areas of the body where you most frequently feel pain, discomfort, or altered sensation (e.g., numb, pins and needles):



Notes from your visit/next steps:

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Medical History

Have you received a diagnosis for psoriatic disease? No Yes When?

Psoriasis Epidemiology Screening Tool (PEST)

Individuals with a psoriasis diagnosis should complete this survey once a year to assess for symptoms of PsA. Share your score with your provider at your next visit.

QUESTION	YES	NO
Have you ever had a swollen joint (or joints)?		
Has a doctor ever told you that you had arthritis?		
Do your fingernails or toenails have holes or pits?		
Have you had pain in your heels?		
Have you had a finger or toe that was completely swollen and painful for no apparent reason?		
Total PEST Score: (1 point for each question answered YES)		

Relevant past procedures, tests, and treatments:

Procedure/Test/Treatment	Date	Notes (provider, results, etc.)

Family history of psoriatic disease or undiagnosed symptoms:

Current medications (prescriptions and any over-the-counter medications you take regularly):

Medication	Dose & Frequency	Notable Side Effects

Your Health Care Professional Team:

Name	Specialty	Contact Info	Date of Last Visit