

LOCALITY

ID NUMBER

DATE

HOUR

PHYSICIAN

I CLINICAL HISTORY

	possible	definite	Current medical control	
			No	Yes
1. Polyarthrititis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 rheumatoid		<input type="checkbox"/> 1		
<input type="checkbox"/> 2 Reiter's disease		<input type="checkbox"/> 1		
<input type="checkbox"/> 3 other reactive				
<input type="checkbox"/> 4 psoriatic				
<input type="checkbox"/> 5 other				
<input type="checkbox"/> 9 not classifiable				
2. Monoarthrititis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 sympt.		<input type="checkbox"/> 1		
<input type="checkbox"/> 1 x-ray		<input type="checkbox"/> 1		
3. Bechterew's disease	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 no symptoms in peripheral joints		<input type="checkbox"/> 1		
<input type="checkbox"/> 2 with symptoms in peripheral joints		<input type="checkbox"/> 1		
<input type="checkbox"/> 9 not classifiable				
4. Peripheral osteoarthrosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 <input type="checkbox"/> 2 knees		<input type="checkbox"/> 1		
<input type="checkbox"/> 1 <input type="checkbox"/> 2 hips		<input type="checkbox"/> 1		
<input type="checkbox"/> 1 <input type="checkbox"/> 2 hands				
<input type="checkbox"/> 1 <input type="checkbox"/> 2 other				
5. Gout	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 sympt.		<input type="checkbox"/> 1		
<input type="checkbox"/> 1 x-ray		<input type="checkbox"/> 1		
6. Total or partial amputation of limb	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 0	<input type="checkbox"/> 1
<input type="checkbox"/> 1 sympt.		<input type="checkbox"/> 1		
<input type="checkbox"/> 1 x-ray		<input type="checkbox"/> 1		

Question 4: 1 = one; 2 = both

7. Cervicobrachial syndrome 1 2 yr. 0 1
1 cervical root syndrome 1 sympt. _____
2 muscular 1 x-ray _____
3 spondylarthrosis _____
4 other defined _____
9 not classifiable _____

8. Low back syndrome 1 2 yr. 0 1
1 disc prolapse 1 sympt. _____
2 sciatica (no prolapse) 1 x-ray _____
3 spondylolisthesis _____
4 spondylarthrosis _____
5 muscular _____
6 other defined _____
9 not classifiable _____

9. Shoulder disease 1 2 yr. 0 1
1 sympt. _____
1 x-ray _____

10. Deformity of foot 1 2 yr. 0 1
1 hallux valgus 1 sympt. _____
2 pes planus 1 x-ray _____
3 digitus malleus _____
4 other defined _____

11. Other defined musculo-
skeletal syndrome 1 2 0 1
1 sympt. _____
1 x-ray _____

12. Non-defined musculoskeletal
pain syndrome 1 2 0 1
1 sympt. _____
1 x-ray _____

0 no history of conditions mentioned above

13. Disease of other system
contributing to musculo-
skeletal symptoms/signs 1 2 yr. 0 1
1 sympt. _____
1 x-ray _____
 what? _____

14. Details, comments: _____

III STATUS

HAND	normal <input type="checkbox"/> 0	RIGHT	ABN <input type="checkbox"/> 1	LEFT	ABN <input type="checkbox"/> 1	ABN
1. DIP JOINTS		ABN <input type="checkbox"/> 1		ABN <input type="checkbox"/> 1		
SWELLING		SS <input type="checkbox"/> 1		SS <input type="checkbox"/> 1		
RESTRICTED MOTION (80°)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
PAIN		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		
2. PIP JOINTS		ABN <input type="checkbox"/> 1		ABN <input type="checkbox"/> 1		
SWELLING		SS <input type="checkbox"/> 1		SS <input type="checkbox"/> 1		
RESTRICTED MOTION (100°)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
PAIN		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		
3. MCP JOINTS		ABN <input type="checkbox"/> 1		ABN <input type="checkbox"/> 1		
SWELLING		SS <input type="checkbox"/> 1		SS <input type="checkbox"/> 1		
RESTRICTED MOTION (90°)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
PAIN		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		
4. CMC-1 JOINT		ABN <input type="checkbox"/> 1		ABN <input type="checkbox"/> 1		
SWELLING		SS <input type="checkbox"/> 1		SS <input type="checkbox"/> 1		
RESTRICTED MOTION (90°)		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
PAIN		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		
5. OTHER FINDINGS		ABN <input type="checkbox"/> 1		ABN <input type="checkbox"/> 1		
MCP ULNAR DEVIATION		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
ATHROPHIA MM. INTEROSS.		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
DUPUYTREN		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 No.		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 No.		
HERBERDEN'S NODULES		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		

ABN = abnormality not included in study standards (specify)

SS = soft tissue swelling

BE = bony enlargement

PM = pain on motion

PP = pain on palpation

Grades of restricted motion

0 = no restriction (to leave unfilled)

1 = suspected or slight (< 20 %)

2 = moderate (20 - 80 %)

3 = severe (> 80 %)

UPPER LIMB

normal 0

RIGHT ABN 1

LEFT ABN 1

ABN

1. WRIST
 SWELLING
 RESTRICTED MOTION (150°)
 PAIN

ABN 1
 SS 1 BE 2
 1 2 3
 PM 1 PM 2

ABN 1
 SS 1 BE 2
 1 2 3
 PM 1 PP 2

2. ELBOW
 RESTR. EXTENSION (0°)
 PAIN
 ELBOW NODULES

ABN 1
 1 2 3
 PM 1 PP 2
 1 2 3

ABN 1
 1 2 3
 PM 1 PP 2
 1 2 3

3. SHOULDER
 LATERAL ABDUCTION (170°)
 ROTATION (150°)
 PAIN

ABN 1
 1 2 3
 1 2 3
 PM 1 PP 2

ABN 1
 1 2 3
 1 2 3
 PM 1 PP 2

SPINE

normal 0

ABN 1

1. NECK
 RESTR. ROTATION (60°)
 RESTR. EXTENSION (45°)
 PAIN IN MOTION
 PAIN ON PALPATION OF TRAPEZIUS MUSCLE

ABN 1
 1 2 3
 1 2 3
 1 2 3
 1 2 3

2. THORACIC AND LUMBAR SPINE
 SCHOBER'S TEST
 RESTR. EXTENSION (35°)
 RESTR. FLEXION
 PAIN IN MOTION
 SCOLIOSIS
 LUMBAR LORDOSIS
 SQUATTING
 ABDOMINAL MUSCLE STRENGTH

ABN 1
 mm
 1 2 3
 1 2 3
 1 2 3
 1 2 3
 1 2 3
 1 2 3

LOWER LIMB

normal 0

RIGHT

ABN 1

LEFT

ABN 1

ABN

1. HIP AND LASÈGUE

ABN 1

NRI

LASÈGUE TEST (75°)

1 2 3 1

ABN 1

NRI

1 2 3 1

MOVEMENT RESTR.

- ABD-ADD (80°)

1 2 3

1 2 3

- EXTENSION

1 2 3

1 2 3

- INT. ROTATION (35°)

1 2 3

1 2 3

- EXT. ROTATION (50°)

1 2 3

1 2 3

- PAIN IN MOTION

1 2 3

1 2 3

2. KNEE

ABN 1

SWELLING

HY 1 SS 2 BE 3

ABN 1

RESTR. EXTENSION (0°)

1 2 3

1 2 3

RESTR. FLEXION (135°)

1 2 3

1 2 3

PAIN

PM 1 PP 2

PM 1 PP 2

3. ANKLE

ABN 1

SWELLING

OED 1 SS 2 BE 3

ABN 1

SUBTAL. MOTION RESTR. (PASS., 60°)

1 2 3

1 2 3

SUBTALAR PAIN

PM 1

PM 1

TALOCRUR. MOTION RESTR. (PASS., 70°)

1 2 3

1 2 3

TALOCRUR. PAIN

PM 1

PM 1

4. ACHILLES TENDON

ABN 1

SWELLING

1 2 3

1 2 3

PAIN

PM 1 PP 2

PM 1 PP 2

OED = oedema

NRI = nerve root irritation

HY = hydrops

FOOT	normal <input type="checkbox"/> 0	RIGHT	ABN <input type="checkbox"/> 1	LEFT	ABN <input type="checkbox"/> 1	ABN
1. MTP-2-5 JOINTS SWELLING RESTR. MOTION (PASS., 80°) PAIN		ABN <input type="checkbox"/> 1 SS <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		ABN <input type="checkbox"/> 1 SS <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		<hr/> <hr/> <hr/> <hr/>
2. MTP-1 JOINT SWELLING RESTR. MOTION (PASS., 80°) PAIN		ABN <input type="checkbox"/> 1 SS <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		ABN <input type="checkbox"/> 1 SS <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 PM <input type="checkbox"/> 1 PP <input type="checkbox"/> 2		<hr/> <hr/> <hr/> <hr/>
3. DEFORMITIES DIGITUS MALLEUS CLAVUS HALLUX VALGUS PES PLANUS OTHER		ABN <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		ABN <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

no findings mentioned above 0

DIAGNOSTIC EVALUATIONS BY FIELD PHYSICIAN

	Diagnoses	Dg. based on	Need of care/control	Adequacy of care/control	Need of new measures
1. POLYARTHRITIS	<input type="checkbox"/> possible <input type="checkbox"/> defined	<input type="checkbox"/> disease history <input type="checkbox"/> symptom history <input type="checkbox"/> status	<input type="checkbox"/> no <input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> inadequate <input type="checkbox"/> proposed not fulfilled <input type="checkbox"/> adequate	<input type="checkbox"/> general practitioner <input type="checkbox"/> specialist <input type="checkbox"/> control of finding
1 rheumatoid 2 Reiter's disease 3 other reactive 4 psoriatic 5 other 9 not classifiable					
2. MONOARTHRITIS	<input type="checkbox"/> joint _____ <input type="checkbox"/>				
3. BECHTEREW'S DISEASE	<input type="checkbox"/> 1 no symptoms in peripheral joints <input type="checkbox"/> 3 not classifiable	<input type="checkbox"/> 2 with symptoms in peripheral joints	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
4. PERIPHERAL OSTEOARTHRITIS	<input type="checkbox"/> 1 knees <input type="checkbox"/> 1 hips <input type="checkbox"/> 2 knees <input type="checkbox"/> 2 hips <input type="checkbox"/> 1 hands <input type="checkbox"/> 2 other	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
5. GOUT	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
6. TOTAL OR PARTIAL AMPUTATION OF LIMB what? _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
7. CERVICOBRACHIAL SYNDROME	<input type="checkbox"/> 1 cervical root <input type="checkbox"/> 4 other defined	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

