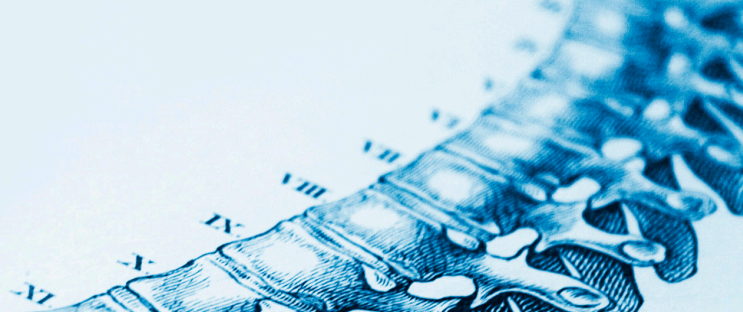


# Patient Visit Planning Tool



**Before your next visit to your rheumatologist, answer the following to share your recent symptoms with your doctor**

**1. In the last month how would you rate the level of your worst pain from your ankylosing spondylitis or non-radiographic axial spondyloarthritis? (0=no pain, 10=worst pain imaginable)**

- 0  1  2  3  4  5  6  7  8  9  10

**2. Where was the location of your pain? How would you describe it (burning, aching, stinging, throbbing)?**

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**3. What time of day do you experience the most pain?**

- morning  afternoon  night

**4. How long are you stiff after getting up in the morning?**

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**5. List anything that worsens the pain**

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**6. List anything that improves the pain**

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**7. How many work days have you missed in the past month?**

- 0-1  2  3-5  If more, specify

**8. How many days have your daily activities been impacted in the past month?**

- 0-1  2  3-5  If more, specify

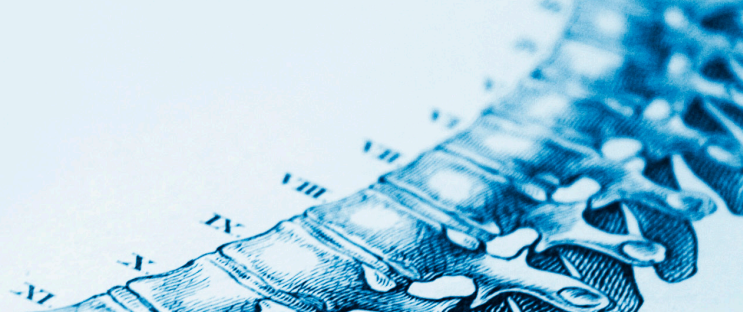
**9. How many days have you had difficulty sleeping in the past month?**

- 0-1  2  3-5  If more, specify

**10. Have you experienced any of the following since your last visit?**

- |  |   |
|--|---|
| <input type="checkbox"/> Eye pain, redness or sensitivity to light | <input type="checkbox"/> Reduced mobility                   |
| <input type="checkbox"/> Fatigue                                   | <input type="checkbox"/> Pain in areas other than the spine |
| <input type="checkbox"/> Red or scaly patches on the skin          | <input type="checkbox"/> Stomach pain or diarrhea           |
| <input type="checkbox"/> Increased stiffness                       | <input type="checkbox"/> Heel swelling or pain              |
| <input type="checkbox"/> Depressed mood                            |   |
| <input type="checkbox"/> Other_____                                |   |

# Patient Visit Planning Tool



**During your visit be sure to let your doctor know the following:**

**1. Have you been following your treatment plan?**

Yes     No

If No, why not?

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**2. Are you satisfied with your current treatment plan?**

Yes     No

If No, why not?

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**3. Have you had any significant health events (hospitalization, procedures, illnesses, etc.) since your last visit?**

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**4. Have you started any new over-the-counter or prescription medication or supplements?**

Yes     No

If Yes, which ones, how much and how often?

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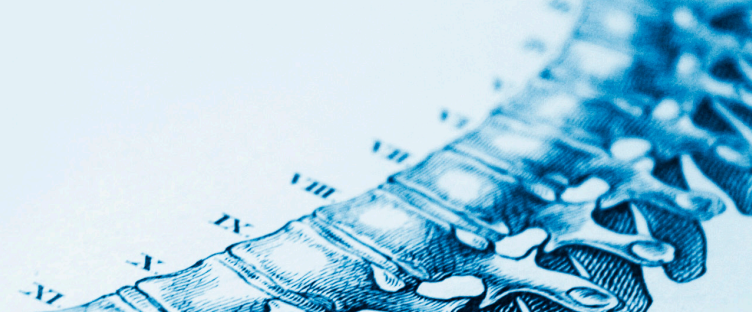
**5. Do you need any medication refills? If Yes, please list below.**

Yes     No

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# Patient Visit Planning Tool

**Questions for your doctor:**

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**Important points from your visit today:**

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