

Rheumatoid Arthritis Evaluation Study (RAES)

Questionnaire Instructions

1. Do not make copies of these forms. Each form of the questionnaire is numbered and will distinguish one patient. We have sent you extra forms if you need them.
2. The RAES questionnaire has two sections, a physician section (red) and a patient section (blue). Tear off the tab on the left hand side of the questionnaire, give the first page to the physician, and the rest of the pages to the patient for completion.
3. Make sure the patient and the physician have answered all of the questions by reviewing the questionnaire for completeness.
4. If the laboratory tests are not available on the day of the examination, wait until they are ready, then enter the ESR/CRP data on the completed form.
5. When ALL of the patient, physician and laboratory information is completed, please fax the forms (except instructions and consent forms) to 316-262-0382.
6. If you have any problems faxing or if you have questions please call us at 800-323-5871 x126.

Please fax completed forms to 316-262-0382



PHYSICIAN SECTION

JOINT	Normal	Tender or pain on motion	Swollen	Deformed or limited motion	JOINT	Normal	Tender or pain on motion	Swollen	Deformed or limited motion
R-PIP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-PIP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-PIP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-PIP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-PIP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-PIP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-PIP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-PIP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-PIP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-PIP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PIP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PIP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MCP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MCP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MCP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MCP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MCP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MCP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MCP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MCP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MCP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MCP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MCP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MCP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	L-Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>
R-Hip	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	L-Hip	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>
R-Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MTP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MTP1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MTP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MTP2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MTP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MTP3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MTP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MTP4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R-MTP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L-MTP5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MTP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MTP Squeeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Duration of RA in years. Round up to the nearest year.

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ESR today: _____

AND/OR

CRP today:

mg/dl mg/L

Physician's assessment of global disease activity:

0	1	2	3	4	5	6	7	8	9	10
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
None		Mild			Moderate			Severe		

Extra-articular manifestations are a part of RA activity in this patient, and were included in my disease activity rating.

Yes No

Approximate number of Randomized Clinical Trials that you have participated in.

0	1	2	3	4	5	6	7	8	9	10 or more
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Office Use Only

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Rheumatoid Arthritis Evaluation Study (RAES)

Patient Questionnaire Instructions

1. You will need a blue or black pen that won't bleed through the paper. Please do not use pencil or red ink.

2. You will see a lot of small squares
These squares should be
marked with an X like this:

Yes No
 Yes No

Be sure to make your X inside the
box, and fairly heavy, so the
computer can read it.

3. You will also see some
boxes that look like this:

--	--

For optimum accuracy, please print carefully
and avoid contact with the edges of the box.
The following will serve as an example:

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

Please--no
fractions or
decimals!!

4. You will also see some scales like the one below. You will need to make a mark in the box
that best corresponds to your answer. These scales are usually 0-100. Read carefully to
determine what the question is asking. In this example, the box marked with an X represents a
person having a great deal of pain.

0 100

NO PAIN SEVERE PAIN

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PATIENT SECTION

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities OVER THE PAST WEEK:

Are you able to:	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please place an X in the box beside any aids or devices that you usually use for any of the above activities:

- Cane
 Crutches
 Walker
 Wheelchair
 Built up or special utensils
 Special or built up chair
 Devices used for dressing (button hook, zipper pull, long handled shoe horn)
 Other (please specify) _____

Place an X in the box beside any categories for which you usually need HELP FROM ANOTHER PERSON:

- Dressing and Grooming
 Arising
 Eating
 Walking

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness in the past week? Place an X in the box that best describes the severity of your pain on a scale of 0-100.

	0		100
NO PAIN	<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"/> <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"/> <input type="checkbox"/> <input type="checkbox"/>	SEVERE PAIN	

Please place an checkmark in one box in each question below that best describes your own health state today.

1. I have no problems in walking about
 I have some problems in walking about
 I am confined to bed

2. I have no problems with self-care
 I have some problems washing or dressing myself
 I am unable to wash or dress myself

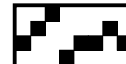
3. I have no problems performing my usual activities
 I have some problems performing my usual activities
 I am unable to perform my usual activities

4. I have no pain or discomfort
 I have moderate pain or discomfort
 I have extreme pain or discomfort

5. I am not anxious or depressed
 I am moderately anxious or depressed
 I am extremely anxious or depressed

How satisfied are you with your HEALTH NOW?

- Very satisfied
 Somewhat satisfied
 Neither satisfied nor dissatisfied
 Somewhat dissatisfied
 Very dissatisfied



We would like to have a record of your past use of arthritis medicines. Please answer the questions below.

Name of Drug	Ever Used?	Using this medication now?	Name of Drug	Ever Used?	Using this medication now?	Name of Drug	Ever Used?	Using this medication now?
Arava (leflunomide)	<input type="checkbox"/>	<input type="checkbox"/>	Penicillamine (Depen, Cupramine)	<input type="checkbox"/>	<input type="checkbox"/>	Minocycline	<input type="checkbox"/>	<input type="checkbox"/>
Enbrel (etanercept)	<input type="checkbox"/>	<input type="checkbox"/>	Imuran (Azathioprine)	<input type="checkbox"/>	<input type="checkbox"/>	Remicade (infliximab)	<input type="checkbox"/>	<input type="checkbox"/>
Gold injections	<input type="checkbox"/>	<input type="checkbox"/>	Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>	Prednisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Gold by mouth	<input type="checkbox"/>	<input type="checkbox"/>	Plaquenil (Hydroxy-chloroquine)	<input type="checkbox"/>	<input type="checkbox"/>	Humira (Adalimumab)	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Rheumatrex)	<input type="checkbox"/>	<input type="checkbox"/>	Cyclosporine	<input type="checkbox"/>	<input type="checkbox"/>	Kineret (Anakinra)	<input type="checkbox"/>	<input type="checkbox"/>

Were you working for pay during the time you had your arthritis or pain problem? Yes No

Did you ever stop working permanently or retire early because of your arthritis or other pain? Yes No

Have you **EVER** had a total joint replacement? Yes No

Have you **EVER** had a joint surgery NOT including a total joint replacement? Yes No

How many years of school have you completed? Please X the box to the left of the number of years of school you have had.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+ _____
 -----Grade School----- -----High School----- -----College----- Post college or Other

Please tell us how old you are: _____ Years

And are you: Male Female

Please tell us your ethnic background: White Asian Native American / Native Canadian / Alaskan Native
 Black Hispanic Puerto Rican Other



