

The Arthritis Research Center  
National Data Bank for Rheumatic Disease  
**ARTHRITIS RESEARCH PROJECT**  
Phase 56

Date you completed this questionnaire:

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FOR OFFICE USE ONLY

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January 2009,

For those of you who are new to our questionnaire, or are returning after some time away, we welcome you. We encourage you to read through the instructions below. They will help to make the time you spend filling out the questionnaire worthwhile for both you and us. You will need to complete EACH page of the survey so we can get your historical information as well as your current information.

Please note that most questions pertain to the time frame of July 1, 2008 to December 31, 2008, unless otherwise noted. Each of you makes a valued contribution to this work. Sometimes people think that their disease is too mild, or too severe, or they aren't taking medication, or some other reason that we might not want them to continue in the study. Nothing could be further from the truth. We need the experience of each of you to further refine and develop this data bank, which continues to be the largest and most comprehensive in the world. We appreciate each and every one of you!

As always, if you need help with your questionnaire, or have a question, call us at 1-800-323-5871 and then follow the instructions and we will be glad to speak with you. You may also fill out the questionnaire online by going to [www.arthritis-research.org](http://www.arthritis-research.org).

Best Wishes and very sincerely yours,

Fred Wolfe, MD

### 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 like this:  Yes  No  
These squares should be marked with an X like this:  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. If more space is needed for any question, please use the comment area on page 12.

5. 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



## BACKGROUND AND MEDICAL HISTORY

Current marital status? *(check one)*

Never Married     Separated     Widowed     Remarried after divorce  
 Married     Divorced     Remarried after death of spouse

Do you smoke cigarettes?     Never     Now     In the Past

If you smoked in the past or currently smoke:    How many years?      How many packs per day?

What is your current occupation? \_\_\_\_\_  
*(Please be specific. For example, math teacher, civil engineer, medical sales.)*

Over your working life what was/is your main occupation? \_\_\_\_\_  
*(Again, please be specific.)*

Currently, what is your **main** form of work?     Paid Work     Housework     Student     Retired     Unemployed     Disabled  
*(mark only one)*

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

**If yes, in what year?**

Did you ever stop working permanently or retire early because of another medical reason?     Yes     No

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Which income group below comes closest to your total household income in the last year (**January-December 2008**) from ALL SOURCES BEFORE TAXES?

Under \$10,000     \$10,000 - 19,999     \$20,000 - 29,999     \$30,000 - 39,999     \$40,000 - 49,999  
 \$50,000 - 59,999     \$60,000 - 69,999     \$70,000 - 79,999     \$80,000 - 89,999     \$90,000 - 99,999  
 \$100,000 or more

In your lifetime have you **EVER** received Social Security **Disability** (Medicare disability) payments?     Yes     No  
*This is NOT the same as Social Security retirement. This is a payment because you are disabled.*

If yes, what was the first year you received these payments?

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Was this due to arthritis?     Yes     No

Now, during the time period **July 1 and December 31, 2008** did you receive any type of disability payments?     Yes     No

*If yes, please complete the section below.*

Source of Disability Payment	Due to any reason?	Due to Arthritis?
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Long term disability from employment .....     Yes     No     Yes     No

Social security disability payments or Medicare disability payments .....     Yes     No     Yes     No

## COMMON HEALTH PROBLEMS

*Please put an X in the first column if you have this problem now. If you have had the problem in the past, put an X in the second column.*

Health Problem	I had this problem in the last 6 months	I had this problem in the past	Health Problem	I had this problem in the last 6 months	I had this problem in the past
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Severe Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Liver problem	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problem	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Neurological problem (like seizures, Parkinson's disease, multiple sclerosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	Fractures of the spine/hip/leg	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>
Lung problem	<input type="checkbox"/>	<input type="checkbox"/>	Problems with prostate (men) Uterus, ovaries, etc. (women)	<input type="checkbox"/>	<input type="checkbox"/>



**Cancer**

Between July 1, 2008 and December 31, 2008 were you told that you had any kind of cancer or malignancy?  Yes  No  
(Please list ALL of the types of cancer diagnosed between July and December on the lines below. For example: leukemia, lymphoma, lung, skin, breast, etc.)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Renal**

Between July 1, 2008 and December 31, 2008 did you have or were you treated for:

Renal or Kidney Failure  Yes  No

**Skin**

Between July 1, 2008 and December 31, 2008 did you have or were you treated for:

Psoriasis  Yes  No  
Shingles (Herpes Zoster)  Yes  No  
Cold sore (Herpes Simplex)  Yes  No  
Human papillomavirus (Genital warts)  Yes  No

**Liver**

Between July 1, 2008 and December 31, 2008 did you have or were you treated for:

Liver problems  Yes  No

**Stomach**

Between July 1, 2008 and December 31, 2008 did you have or were you treated for :

- An ulcer (a stomach or duodenal ulcer)?  Yes  No

If yes, which of the following did your physician use to diagnose your ulcer? (Mark all that apply)

X-ray  Endoscopy  Talking to you about your symptoms

- Helicobacter pylori or H. Pylori, a stomach bacteria?  Yes  No

**MS and Lupus**

Between July 1, 2008 and December 31, 2008 did you have or were you treated for:

- Multiple Sclerosis (MS)?  Yes  No

If you had Multiple Sclerosis (MS) before July 1, 2008 did the problems get better, get worse or stay the same?

Get Better  Get Worse  Stay the Same

- Systemic Lupus, Lupus or any other auto immune disorder?  Yes  No  
(e.g. Sjogren's, Crohn's Disease, Ulcerative Colitis, Guillain Barre, thyroid disorder, etc.)?

**This does NOT include RA.**

If yes, what was the diagnosis? \_\_\_\_\_

**Lungs**

Between July 1, 2008 and December 31, 2008:

Were you diagnosed for the FIRST TIME with Tuberculosis (TB):  Yes  No

Did you have a TB skin test in the last year?  Yes  No

\_\_\_\_\_



**Cardiovascular (Heart)**

Between **July 1 and December 31, 2008** did you have or were you treated for :

- Heart Failure  Yes  No
- Heart Attack/ Myocardial Infarction (MI)  Yes  No
- High Cholesterol  Yes  No
- Stroke  Yes  No
- High Blood Pressure  Yes  No

**Joint Problems**

**Between July 1 and December 31, 2008** did you have a total joint replacement?  Yes  No  
 If yes, please record joint replacements from July to December 2008 on page 6.

Please select all appropriate answers.  Hip  Knee  Shoulder  Other  None

Not counting fractures that occurred in the last 6 months, did you have any fractures in the **last 5 years**?  Yes  No

**Between July 1 and December 31, 2008** did you have joint resurfacing (not a joint replacement)?  Yes  No

**Infections**

Did you have any infections from **July 1 and December 31, 2008**?  Yes  No  
 If "yes" please answer section directly below.

Type of Infection - please place an X next to the type of infection that you had between <b>July 1 and December 31, 2008</b> and then tell us the number of infections and hospitalizations.	Number of Infections You Had During this Period ( <b>July 1 and December 31, 2008</b> )	Did you receive or were you treated with intravenous antibiotics (given in the vein) for an infection as an outpatient (not in the hospital)?	Number of Hospital Admissions for Infections <i>(Be sure to mark any hospitalizations on page 6)</i>
<input type="checkbox"/> Septicemia (sepsis, blood stream infection)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Pneumonia, coccidiomycosis or other lung infection (not bronchitis or upper respiratory infections, ie. not "colds".)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Pneumocystis, histoplasmosis, cytomegalic infections, blastomycosis, lysteria or listeriosis, aspergillosis, cryptococcus, nocardia, toxoplasmosis, cryptosporidiosis or any other fungal infection ( <b>NOT</b> skin or nail infections)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Skin infections (infected skin ulcer, cellulitis, infected nodules)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Urinary tract infection / Kidney infection / Bladder infection	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Bone/Joint infection (osteomyelitis, septic joint, infected artificial joint)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Influenza (Flu)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Cold or Upper respiratory illness (URI)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3
<input type="checkbox"/> Other, please specify _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3





## JOINT/BODY PAIN

Please indicate below the amount of pain and/or tenderness you have had over THE PAST 7 DAYS in each of the joint and body areas listed below. Please make an X in the box that best describes your pain or tenderness. Be sure to mark both right side and left side separately. If you have had no pain or tenderness in a particular joint or body part, mark "None." *There should be an answer for every joint or body part listed.*

JOINTS	None	Mild	Mod	Severe	OTHER BODY AREAS	None	Mild	Mod	Severe
Shoulder, Lt. Shoulder, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw, Lt. Jaw, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow, Lt. Elbow, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist, Lt. Wrist, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand knuckles, Lt. Hand knuckles, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper arms, Lt. Upper arms, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger knuckles, Lt. Finger knuckles, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower arms, Lt. Lower arms, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip, Lt. Hip, Rt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper leg, Lt. Upper leg, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee, Lt. Knee, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower leg, Lt. Lower leg, Rt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle, Lt. Ankle, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Chest Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ball of foot, Lt. Ball of foot, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heel, Lt. Heel, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot arch, Lt. Foot arch, Rt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Considering **ALL THE WAYS THAT YOUR ILLNESS AFFECTS YOU, RATE HOW YOU ARE DOING** on the following scale. Place an X in the box below that best describes how you are doing on a scale of 0-100.

VERY WELL **0**                      **100** VERY POOR

In general, how active was your arthritis or fibromyalgia from **July 1 through December 31, 2008?** Place an X in the box below to indicate the amount of activity on a scale of 0-100.

NOT ACTIVE AT ALL **0**                      **100** EXTREMELY ACTIVE

In terms of joint tenderness and swelling, how active is your arthritis or fibromyalgia **TODAY?** Place an X in the box below to indicate the amount of tenderness and swelling on a scale of 0-100.

NOT ACTIVE AT ALL **0**                      **100** EXTREMELY ACTIVE

We are interested in knowing about any problems that you may have been having with fatigue. How much of a problem has fatigue or tiredness been for you **IN THE PAST WEEK?** Place an X in the box below that best describes the severity of your fatigue on a scale of 0-100.

FATIGUE IS NO PROBLEM **0**                      **100** FATIGUE IS A MAJOR PROBLEM



## HOSPITALIZATIONS

**PLEASE DO NOT LEAVE THIS PAGE BLANK!**

**Did you stay in the hospital overnight for any reason between July 1 and December 31, 2008?**  Yes  No  
**If yes, please list all of those below.**

Reason for Hospitalization	Hospital Name, City, State	Month Admitted	Number of nights in the hospital	Type of Stay
1) _____ _____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-13 <input type="checkbox"/> 14 or more	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>
2) _____ _____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-13 <input type="checkbox"/> 14 or more	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>
3) _____ _____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-13 <input type="checkbox"/> 14 or more	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>
4) _____ _____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> 1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-13 <input type="checkbox"/> 14 or more	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>

**Between July 1 and December 31, 2008, have you been to a hospital emergency room (ER)?**  Yes  No  
**(Do not include after-hours clinics or urgent care centers)**

If yes, how many total ER visits did you have?  1  2  3  4  5 or more

**Between July 1 and December 31, 2008, were you a patient in a nursing or convalescent home or live-in rehabilitation center?**  Yes  No

If yes, how many days did you spend in that center?  1-7  8-14  15-21  22-28  More than 28

**Between July 1 and December 31, 2008, have you had any outpatient surgery, endoscopy, gastroscopy or biopsy procedures?**  Yes  No  
**If yes, please list all of those below:**

Surgery/Procedure	Doctor's Name	Location and Address of Hospital or Doctor's Office	Month Procedure Done	Type of Procedure
1) _____	_____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>
2) _____	_____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>
3) _____	_____	_____	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Medical <input type="checkbox"/> Surgical <input type="checkbox"/>



## MEDICATIONS

We are interested in ALL of the medicine you have taken in the PAST 6 MONTHS (**July 1 to December 31, 2008**). This includes both prescription and non-prescription medicines that you take for a health problem or to prevent a health problem. This includes: your arthritis and pain-relieving medicines; stomach medicines; heart medicines; blood pressure medicines; cholesterol, insulin; hormones; topicals/creams; medicine for a headache or a "cold"; and "health food" type supplements like vitamins, herbs, and minerals. This would include things like glucosamine and chondroitin. In other words, all medications!

● **SPECIAL INSTRUCTIONS ABOUT INJECTIONS:** Include ALL injectable and infusion medications including Remicade, Humira, Enbrel, Kineret, Methotrexate, Rituxan, Orenzia, Cortisone, Aristocort, Gold, Hyalgan, Synvisc, Prosurba treatments, Forteo, insulin and pain blocks.

1. Place the injection size or the strength of the injection (if you know it) in the "Average Pill Strength" column. For example, for Methotrexate you might write .6 ml or .6 cc (injection size) or 15 mg (the strength).
2. In the "Pills used per day" column tell us how often you take the injections if taken on a regular basis. Here are some examples that would work:
  - 2 per week
  - 3 per month
  - 1 every 8 weeks
  - 1 every 4 months

Write in the number of injections AND the time period as shown above that best describes how you receive your injections.

- Include your arthritis medicines like Arava, Celebrex, Prednisone, Methotrexate (MTX), Gold, Plaquenil, Daypro, Etodolac, Relafen, Ibuprofen, and Naprosyn. **For oral Methotrexate (MTX) please indicate the number of pills used per week instead of per day.**
- Since some arthritis medicines may bother your stomach, please tell us about any stomach medicines that you take like Prevacid, Pepcid, Prilosec, Zantac, Tagamet, Tums, etc.
- Be sure to include medicines like Aspirin and Acetaminophen (Tylenol), or any medicines that contain Aspirin or Acetaminophen (Tylenol). When recording Aspirin, please tell us what type it is: for example, regular, enteric coated, buffered, etc.
- Also include pain medications like Ultram, Darvocet, and medicines like vitamin D, calcium, fluoride, estrogens, and osteoporosis drugs.
- If you are taking Methotrexate please indicate if it's a pill or an injection by writing "Methotrexate pill" or "Methotrexate Inj.".

Pages 7, 8 and 9 are for you to write in oral and injectable prescriptions and medicines.

If you had a side effect to any medicine you have taken between **July 1 to December 31, 2008**, please be sure to give us the details about that side effect on page 10 and 11. Also, if you stopped taking a medication, tell us why on page 11.

**Mark here if you took NO medications from July - December 2008:**

### Medicines Taken from July 1 - December 31, 2008

<u>Drug Name</u> <small>*If injection see special instructions above</small> <u>Please Print</u>	Is this a prescription?	Average Pill Strength  For Injections see instructions	Average days used per month?	Pills Used Per Day  For Injections see instructions	Check any month used, even if only for one day	Were you still taking as of 12/31/08? (If no, see pg 11)	Did you start this medicine between July 1 and December 31, 2008?	Did you have a side effect to this medicine? (If yes, see pg 10 & 11)
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

Continued on next page

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**DRUGS CONTINUED JULY 1- DECEMBER 31, 2008**

<b>Drug Name</b> *If injection see special instructions on pg 7.  Please Print	Is this a prescription?	Average Pill Strength  For Injections see instructions	Average days used per month?	Pills Used Per Day  For Injections see instructions	Check any month used, even if only for one day	Were you still taking as of 12/31/08? (If no, see pg 11)	Did you start this medicine between July 1 and December 31, 2008?	Did you have a side effect to this medicine? (If yes, see pg 10 & 11)
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Yes  <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

**Continued on next page**



**DRUGS CONTINUED JULY 1- DECEMBER 31, 2008**

<u>Drug Name</u>	Is this a prescription?	Average Pill Strength	Average days used per month?	Pills Used Per Day	Check any month used, even if only for one day	Were you still taking as of 12/31/08? (If no, see pg 11)	Did you start this medicine between July 1 and December 31, 2008?	Did you have a side effect to this medicine? (If yes, see pg 10 & 11)
<b>*If injection see special instructions on pg 7.</b>		<b>For Injections see instructions</b>		<b>For Injections see instructions</b>				
<u>Please Print</u>								
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-31		<input type="checkbox"/> All <input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Drug Side Effects You Experienced between July 1 and December 31, 2008**

We now need some additional information about any side effects that you marked on pages 7-9. Below and on the next page are spaces for side effects to three separate drugs. If you need more room, just write us a note and include it with this form when you send it back to us.

**Drug causing side effect: 1)** \_\_\_\_\_

Did you STOP the drug because of a side effect?  Yes  No

Did you change the dosage of the drug because of a side effect?  Yes  No

What side effects did you experience? Please list.

How SEVERE was each side effect?

1. \_\_\_\_\_

Mild  Moderate  Severe

2. \_\_\_\_\_

Mild  Moderate  Severe

3. \_\_\_\_\_

Mild  Moderate  Severe

Because of these side effects, did you have to: (mark all that apply)  Take additional medicine  Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

No time lost  1-3 days  4-7 days  8-10 days  11-20 days  21-30 days  More than 30 days

What was the month that you first began experiencing the side effect(s) to this drug?  Jul  Aug  Sep

Do you still have any of these side effects?  Yes  No  Oct  Nov  Dec

About how long did the side effects last?

Less than 1 week  1-3 wks  3-4 weeks  1-2 months  2-3 months  3-4 months  4-5 months  5-6 months

How certain are you that the above drug caused the side effects you described?  Very certain  Fairly certain  A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer?  Yes  No (Be sure to mark any hospitalizations on page 6)

**Drug causing side effect: 2)** \_\_\_\_\_

Did you STOP the drug because of a side effect?  Yes  No

Did you change the dosage of the drug because of a side effect?  Yes  No

What side effects did you experience? Please list.

How SEVERE was each side effect?

1. \_\_\_\_\_

Mild  Moderate  Severe

2. \_\_\_\_\_

Mild  Moderate  Severe

3. \_\_\_\_\_

Mild  Moderate  Severe

Because of these side effects, did you have to: (mark all that apply)  Take additional medicine  Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

No time lost  1-3 days  4-7 days  8-10 days  11-20 days  21-30 days  More than 30 days

What was the approximate month that you first began experiencing the side effect(s) to this drug?  Jul  Aug  Sep

Do you still have any of these side effects?  Yes  No  Oct  Nov  Dec

About how long did they last?

Less than 1 week  1-3 wks  3-4 weeks  1-2 months  2-3 months  3-4 months  4-5 months  5-6 months

How certain are you that the above drug caused the side effects you described?  Very certain  Fairly certain  A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer?  Yes  No (Be sure to mark any hospitalizations on page 6)

\_\_\_\_\_

Continued on page 11

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**Drug Side Effects You Experienced between July 1 and December 31, 2008, continued**

**Drug causing side effect:** 3) \_\_\_\_\_

Did you STOP the drug because of a side effect?  Yes  No

Did you change the dosage of the drug because of a side effect?  Yes  No

What side effects did you experience? Please list.

How SEVERE was each side effect?

1. \_\_\_\_\_  Mild  Moderate  Severe
2. \_\_\_\_\_  Mild  Moderate  Severe
3. \_\_\_\_\_  Mild  Moderate  Severe

Because of these side effects, did you have to: (mark all that apply)  Take additional medicine  Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

- No time lost  1-3 days  4-7 days  8-10 days  11-20 days  21-30 days  More than 30 days

What was the month that you first began experiencing the side effect(s) to this drug?  Jul  Aug  Sep

Do you still have any of these side effects?  Yes  No  Oct  Nov  Dec

About how long did the side effects last?

- Less than 1 week  1-3 wks  3-4 weeks  1-2 months  2-3 months  3-4 months  4-5 months  5-6 months

How certain are you that the above drug caused the side effects you described?

- Very certain  Fairly certain  A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer?

- Yes  No (Be sure to mark any hospitalizations on page 6)

**For any of the medicines on pages 7-9 that you stopped taking between July 1 and December 31, 2008, please give us the additional information requested below.**

Name of Drug You Stopped	Why Stopped? (X all that apply)	Month stopped in 2008	Between July 1 and December 31, 2008, did you start another medicine to replace it?	If Yes, which Medicine?	Were you taking that new medicine as of 12/31/2008?
1.	<input type="checkbox"/> Didn't work <input type="checkbox"/> Side effects <input type="checkbox"/> Cost <input type="checkbox"/> Other	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
2.	<input type="checkbox"/> Didn't work <input type="checkbox"/> Side effects <input type="checkbox"/> Cost <input type="checkbox"/> Other	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>
3.	<input type="checkbox"/> Didn't work <input type="checkbox"/> Side effects <input type="checkbox"/> Cost <input type="checkbox"/> Other	<input type="checkbox"/> Jul <input type="checkbox"/> Oct <input type="checkbox"/> Aug <input type="checkbox"/> Nov <input type="checkbox"/> Sep <input type="checkbox"/> Dec	Yes No <input type="checkbox"/> <input type="checkbox"/>		Yes No <input type="checkbox"/> <input type="checkbox"/>



**We need some information to keep our records current. We don't release this information to anyone.** It is to help us keep track of you for mailing and telephone purposes.

Please list below the names and numbers of two people who don't live with you but are likely to know how to contact you.

1) Name \_\_\_\_\_

Area  
Code &  
Phone

-    -

**Your Home Phone:**

-     -

**Spouse's first name:**

2) Name \_\_\_\_\_

Area  
Code &  
Phone

-    -

**Alternate Phone Number:**

-     -

**Best time of day to call you:**

**Please enter the last 4 digits of your Social Security Number.** This enables the NDB to distinguish participants with similar names and home cities. It cannot be used to identify you in any way.

**E-mail address: (please print)**

**Please tell us the name of the doctor who is currently providing your arthritis care.**

**Dr. Name:** \_\_\_\_\_

**Dr. Address:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**If you have any comments, additional information or any problems that you think are important that we didn't ask about, please explain below.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**RELEASE OF MEDICAL INFORMATION**

This page requests permission for us to review your medical records pertaining to your involvement in this research program. This information will be kept strictly confidential and used for research purposes only.

*PLEASE USE INK AND PRINT*

Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Optional

Covering records from the period: 06/30/2008 through present. Purpose of disclosure: Long term outcome research in arthritis.

Information required: Any of the following with ICD coding of primary and secondary diagnoses

- Discharge Summary (procedure) \_\_\_\_\_
- Biopsy Report (area) \_\_\_\_\_
- Out Patient Report (procedure) \_\_\_\_\_
- Other Report (procedure) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

National Databank for Rheumatic Disease will not condition treatment, payment, enrollment or eligibility for benefits whether I sign the authorization.

Federal law protects the information disclosed pursuant to this Authorization. I understand that this information is confidential and will be used for research purposes only, and is not subject to redisclosure except for that allowed by law.

I have carefully read the above consent form and understand and know its contents. I have signed this consent of my own free will and consider myself bound by the provisions contained in the consent. I understand that I have the right to revoke (cancel) this authorization at any time by writing to Medical Records Acquisition, National Databank for Rheumatic Diseases, 1035 N. Emporia STE 288, Wichita, KS 67214 and that it will not apply to any information released before the written revocation is received. Upon the lapse of six (6) months from the date of signature this consent will automatically expire without my express revocation.

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship if not signed by Patient \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Office Use**

This is to authorize that medical information regarding the above identified person be released:

FROM: \_\_\_\_\_  
Name of Facility to Release Information

\_\_\_\_\_ Address of Facility to Release Information

TO: Deb Molina  
The Arthritis Research Center Foundation / National Data Bank for Rheumatic Disease  
1035 N Emporia STE 288  
Wichita KS 67214  
Phone: 316-263-2125 FAX: 316-263-0761

**PHOTOCOPY OF THIS AUTHORIZATION SHOULD BE TREATED IN THE SAME MANNER AS THE ORIGINAL**

