Arthritis Research Questionnaire

Thank you for agreeing to participate in the arthritis outcome studies. Please complete the information about yourself on this page. After that, complete the other side. Then give the questionnaire to your rheumatologist or staff member. Thank you.

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.

Today's date is (mm/dd/yy):

☐☐ / ☐☐ / ☐☐☐☐

month day year

My rheumatologist's name is:

Last 4 digits of social security number:

First Name

MI

Last Name

Street Address

City

State

Zip

(Area Code) and Telephone Number

Best time to call you?

If you want us to contact you by email, please provide:

(Area Code) and Alternate Telephone Number

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 your date of birth (mm/dd/yy):

month day year

☐☐ / ☐☐ / 1 9 ☐☐

And are you: ☐ Male ☐ Female

Current marital status? ***(check one)***

☐ Never Married ☐ Separated ☐ Widowed ☐ Remarried after divorce

☐ Married ☐ Divorced ☐ Remarried after death of spouse

Please tell us your ethnic background:

☐ White, not of hispanic origin ☐ Asian or Pacific Islander ☐ American Indian or Alaska Native

☐ Black, not of hispanic origin ☐ Hispanic ☐ Other

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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 0-10.

VERY WELL **0** ☐ **10** VERY POOR

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 (0)	With Some Difficulty (1)	With Much Difficulty (2)	Unable To Do (3)
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Get on/off toilet?	☐	☐	☐	☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Do yard work (outside work or activities)?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐
Go up two or more flights of stairs?	☐	☐	☐	☐

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 0-10.

FATIGUE IS NO PROBLEM **0** ☐ **10** FATIGUE IS A MAJOR PROBLEM

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 0-10.

NO PAIN **0** ☐ **10** SEVERE PAIN

FOR DOCTOR'S USE ONLY

Date of first symptom: (i.e. date of onset)
If month is not known, just enter year. _____ / _____

Primary Diagnosis:

☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Osteoarthritis of the hands

☐ Osteoarthritis of the knee ☐ Osteoarthritis of the hip

☐ Other arthritis-type diagnosis (please specify) _____

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