Multi-Dimensional Questionnaire for Patient Reported Outcome Measures - Fibromyalgia

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question. There is **no right or wrong answer**. Please answer exactly as **YOU** think or feel.

1.We are interested in learning how your illness affects your ability to function in daily life. Please tick (√) the ONE best answer that describes your usual abilities OVER THE PAST WEEK:

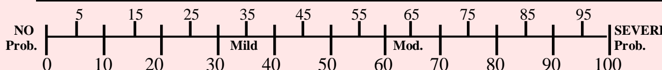
Fn. Disability

QoL

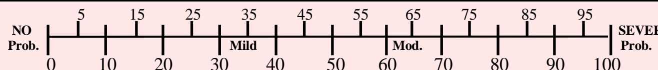
Over the LAST WEEK, were you able to	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable TO DO
1. Get on and off the toilet?	....	....	....	....
2. Dress yourself, including tying shoelaces & putting on socks	....	....	....	....
3. Bend down to pick up object off the floor	....	....	....	....
4. Sit for long periods of time e.g. working on flat topped table or desk	....	....	....	....
5. Lie down / sleep on your back	....	....	....	....
6. Stand up from a chair without arms?	....	....	....	....
7. Walk outdoors on flat ground including crossing the road	....	....	....	....
8. Play with / look after children	....	....	....	....
9. Go up 2 or more flights of stairs	....	....	....	....
10. Do outside work (such as DIY/ gardening/ lifting)	....	....	....	....

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable TO DO	**Not Applicable**
1. Get a good night's sleep?	....	....	....	....	....
2. Deal with the usual stresses of daily life?	....	....	....	....	....
3. Cope with social/ family activities?	....	....	....	....	....
4. Deal with feelings of anxiety or being nervous?	....	....	....	....	....
5. Deal with feelings of low self esteem or feeling blue?	....	....	....	....	....
6. Get going in the morning?	....	....	....	....	....
7. Do your work as you used to do?	....	....	....	....	....
8. Deal with any worries about your future?	....	....	....	....	....
9. Continue doing things you used to do, despite tiredness?	....	....	....	....	....
10. Continue your relationship with your partner (husband/wife)?	....	....	....	....	....

2. How much of a problem has SLEEP (i.e., resting at night) been for you OVER THE PAST WEEK?



3. How much of a problem has waking up UN-REFRESHED been for you OVER THE PAST WEEK?



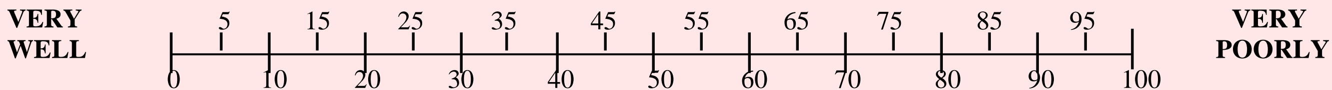
Sleep

Unref. sleep

4. Considering all the ways your Symptoms may be affecting you AT THIS TIME
Please put a circle around the number that best indicates how well you are doing:

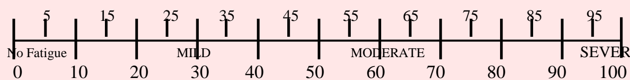
PGA

VERY WELL

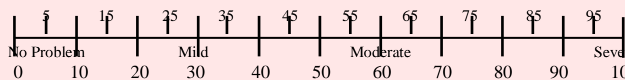


VERY POORLY

5. How much of a problem has UNUSUAL FATIGUE or tiredness been for you OVER THE PAST WEEK?



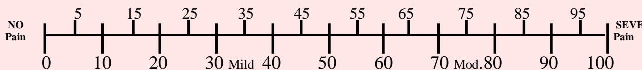
6. How much of a problem has Trouble Thinking or remembering been for you OVER THE PAST WEEK?



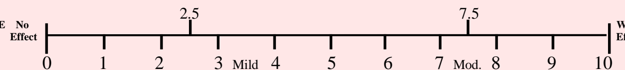
Fatigue

Thinking

7. OVER THE PAST WEEK how would you rate the severity of your body PAIN?



8. OVER THE PAST WEEK how much of a problem has your mood (feeling down / anxious) affected you?



Pain

Mood

Right	Left
Upper Limb	
Shoulder Girdle	Shoulder Girdle
Upper Arm	Upper Arm
Lower Arm	Lower Arm
Lower Limb	
Outer Hip Area	Outer Hip Area
Upper Leg	Upper Leg
Lower Leg	Lower Leg
Jaw	
Jaw (Rt.)	Jaw (Lt.)
Trunk	
Neck	Chest
Upper Back	Abdomen
Lower Back	*WPI score: /19*

Have you experienced any of these symptoms in the past months?	"Yes"	"No"
Pain or Cramps on the Lower Abdomen		
Depression		
Headache		

Please place (√) in front of the painful area(s) over your body which you feel painful **TODAY.**

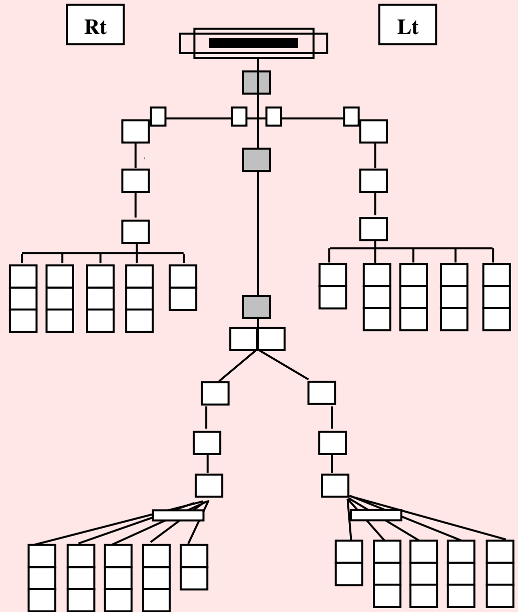
WPI score: (0-19)

Somatic Symp.:

Wolfe et al. ACR 2010

Please place a (X) in the appropriate box to indicate in which of your JOINTS you feel painful **TODAY**

Tender Joints



Neck
Shoulder
Shoulder Blade
Elbow
Wrist
Knuckles / Fingers
Low Back
Sacroiliac Joint
Hip
Knee
Ankle
Top Foot
Toes

Please tick (☐) if you have experienced or diagnosed with any of the following OVER THE LAST 6-MONTHs:

						Cardiovascular Risk Assessment	
Fever		Dry Eye / Dry Mouth		Loss of height / Vertebral Fracture			
Weight gain (> 10 lbs)		Vitamin D deficiency		Weakness/Paralysis of arms or legs		Age > 50 years old	
Weight Loss (> 10 lbs)		Thyroid Disease		Numbness or tingling		High Blood pressure	
Loss of appetite		Parathyroid gland Disease		Muscle pain, ache or cramps		High Cholesterol	
Soreness in the mouth		Headache		Problems with thinking/memory		Current Smoker	
Genital Ulcers		Wheezing in the chest		Absent from work due to body pains		Ischemic heart Disease	
Skin Rash		Cough/ Shortness of breath		Short plans for having a baby		Stroke	
Psoriasis		Heartburn		Sexual relationship Problems		Overweight/under weight	
Hepatitis C infection		Dark or bloody stools		Problems with erection (for men)		Diabetes Mellitus	
Kidney Disease		Feeling Sickly / Nausea		Falls Risk Assessment		The section below is for official use. Please do not tick	
Unusual bruising or bleeding		Constipation		>1 Fall in the last year			
Inflammatory bowel Disease		Diarrhea		Problems with your sight		Sex: Male / Female	
Joint Pain / Swelling		Problems with urination		Loss of your balance		BMI: BP:	
Coeliac disease		Osteoporosis		Change in Gait / Walking Speed		WPI: Somatic: SS:	
Hearing Probs/Ringing in the ears		Recent Fractures		Weakness of your grip strength		ESR: CRP:	

The statements below concern your personal beliefs. Please circle the number that best describes how do you feel about the statement. 0 = Not at all; 10 = Strongly Agree

mRAI

Statement	0 – 10
1. My condition is controlling my life.	0 1 2 3 4 5 6 7 8 9 10
2. I would feel helpless if I could not rely on other people for help with my condition.	0 1 2 3 4 5 6 7 8 9 10
3. I am concerned that medicines can not help me.	0 1 2 3 4 5 6 7 8 9 10
4. I've concerns regarding side effects of medications used to treat my condition.	0 1 2 3 4 5 6 7 8 9 10
5. I often do not take my medicines as directed.	0 1 2 3 4 5 6 7 8 9 10
6. No matter what I do, or how hard I try, I just can not seem to get relief from my symptoms.	0 1 2 3 4 5 6 7 8 9 10
7. I am not coping effectively with my condition.	0 1 2 3 4 5 6 7 8 9 10
8. Sometimes I feel my condition is beyond both my and my doctor's control.	0 1 2 3 4 5 6 7 8 9 10
9. Sometimes my condition makes me feel like giving up.	0 1 2 3 4 5 6 7 8 9 10
10. Due to my condition, sometimes I feel I am a burden to those close to me.	0 1 2 3 4 5 6 7 8 9 10

Date: / / 201

☐ **I consent to my clinical data being used for research/audit.**

Signature of the patient: ……………………………………………

Patient:

D.O.B.: