Multi-Dimensional Questionnaire for Patient Reported Outcome Measures-Arthritis

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. Dis.

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. Use your grip strength e.g. open previously opened Jars Or lift a saucepan during cooking?	.....	.....	.....	.....
3. Dress yourself, including tying shoelaces & doing buttons?	.....	.....	.....	.....
4. Stand up from a chair without arms?	.....	.....	.....	.....
5. Wait in a line for 15 minutes?	.....	.....	.....	.....
6. Reach and get down a 5-pounds-object (such as a bag of sugar) from just above your head?	.....	.....	.....	.....
7. Walk outdoors on a flat ground?	.....	.....	.....	.....
8. Go Up 2 or more flights of stairs?	.....	.....	.....	.....
9. Do house work / DIY jobs around the house?	.....	.....	.....	.....
10. Move heavy objects?	.....	.....	.....	.....

QoL

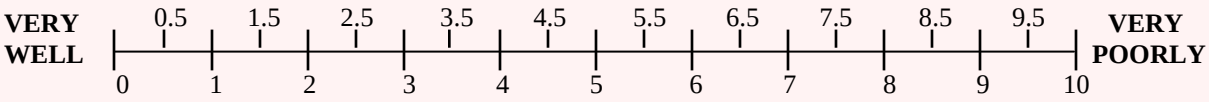
					Not Applicable
1. Get a good night's sleep?	.....	.....	.....	.....	.....
2. Deal with the usual stresses of daily life?	.....	.....	.....	.....	.....
3. Cope with social/ family activities?	.....	.....	.....	.....	.....
4. Deal with feelings of anxiety or being nervous?	.....	.....	.....	.....	.....
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 PAIN have you had because of your arthritis/ joint or body ache OVER THE PAST WEEK? Please put a circle around the number that best indicates your level of pain:

Pain

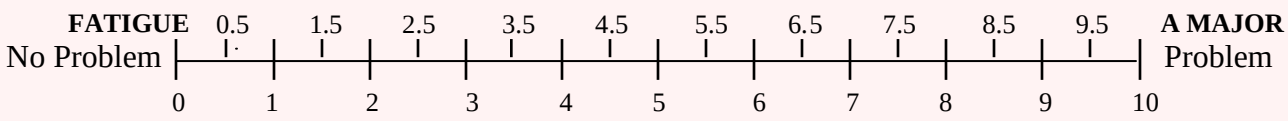
3. Considering all the ways your arthritis/ joint or body ache may be affecting you AT THIS TIME Please put a circle around the number that best indicates how well you are doing:

PGA



4. **How much of a problem has UNUSUAL FATIGUE or tiredness been for you OVER THE PAST WEEK? (please put a circle around the number that best indicates your fatigue)**

Fatigue



5. OVER THE LAST WEEK when you awakened in the morning, did you feel stiff?

MS

YES: □ Please indicate the number of **minutes** ....., or **hours** ..... until you are as limber as you will be for the day.

No: □

Clin Exp Rheumatol 2010; 28:734-744

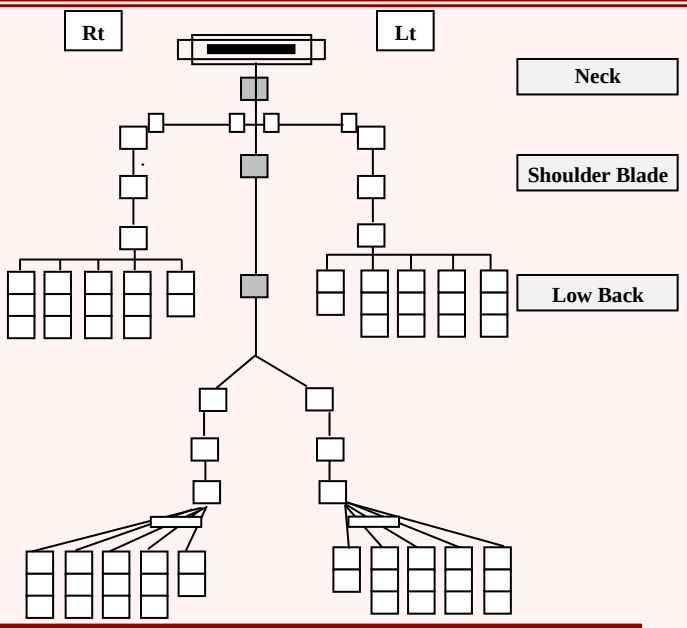
6. Please place a (X) in the appropriate box to indicate in which of your joints you feel painful TODAY.

Alternatively you can put a figure 1, 2 or 3 to describe the severity of the pain you feel in any joint as follows:

1 = mild pain,
2 = moderate pain,
3 = severe pain.

Tender Joint count	
Pt.	Phys

Shoulder
Elbow
Wrist
Knuckles / Fingers
Hip
Knee
Ankle
Top Foot
Toes



7. Please tick (√) if you have experienced any of the following OVER THE LAST MONTH:

Fever		Dry Eye		Gynecological problem		Cardiovascular Risk Assessment	
Weight gain (> 10 lbs)		Dry Mouth		Short plans for having a baby		Age > 50 years old	
Weight Loss (> 10 lbs)		Other eye problems		Sexual Relationship Problems		High Blood pressure	
Loss of appetite		Headache		Problems with erection (for men)		High Cholesterol	
Trouble swallowing		Shortness of breath		Kidney problems		Current Smoker	
Soreness in the mouth		Wheezing / asthma		Absent from work due to joint pain		Ischemic Heart Disease	
Bleeding/inflammation of the gum		Cough		> 3 Alcoholic drinks per day		Stroke	
Psoriasis		Heartburn		Lost Height		Irregular Heart beats	
Unusual bruising or bleeding		Feeling Sickly / Nausea		Had a recent fracture		Diabetes Mellitus	
Numbness or tingling		Constipation		Falls Risk Assessment		The section below is for official use. Please do not tick	
Loss of hair		Diarrhea		Loss of your balance			
Swollen Glands		Dark or bloody stools		Problems with your sight		ESR:	CRP:
Problems with hearing		Problems with urination		Weakness of your grip strength		SJC:	RF:
Thyroid Disease		Pulmonary Embolism / DVT		>1 Fall in the last year		DAS- :	BMI:
Muscle pain, ache or weakness		Diagnosed to have cancer		Change in Gait / Slow walking speed		B/P: /	Chol:

8. 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

RAI

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.: