Multi-Dimensional Questionnaire for Patient Reported Outcome Measures-SLE

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.

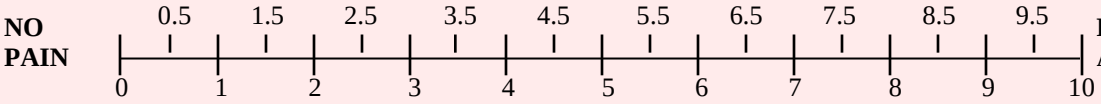
Over the LAST WEEK, were you able to	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable TO DO	Not Applicable
1. Get on and off the toilet?	.....	.....	.....	.....	
2. Use your grip strength e.g. open previously opened Jars Or lift a saucepan during cooking?	.....	.....	.....	.....	
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

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)?	.....	.....	.....	.....	.....

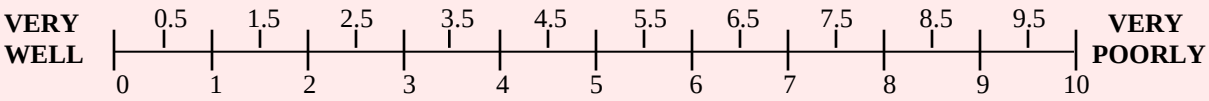
2. How much PAIN or body ache have you had because of Lupus disease OVER THE PAST WEEK?
Please put a circle around the number that best indicates your level of pain:

Pain



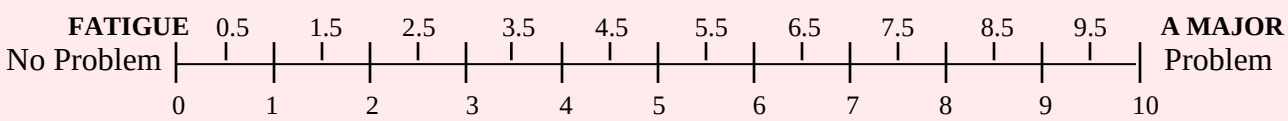
3. Considering all the ways Lupus may be affecting you AT THIS TIME
Please put a circle around the number that best indicates how well you are doing:

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: □

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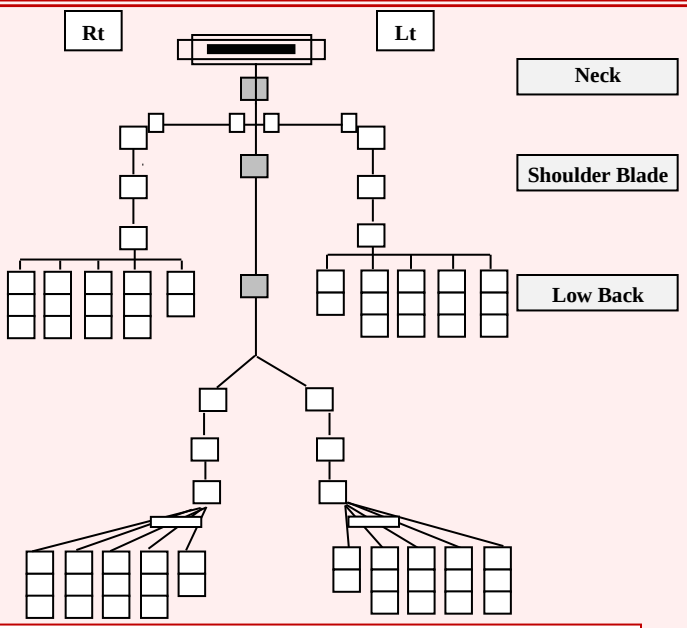
6. Please place a (X) in the appropriate box to indicate in which of your joints you feel painful TODAY.

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 10-days:

Fits / seizures		Tender finger nodules		Gynecological problem		Cardiovascular Risk Assessment	
Hallucinations		Muscle pain		Short plans for having a baby		Age > 50 years old	
Illogical thinking		Muscle weakness		Miscarriage		High Blood pressure	
Bizarre/disorganized behavior		New/recurrent skin rash		Sexual Relationship Problems		High Cholesterol	
Difficulty to focus		Patchy or diffuse loss of hair		Problems with passing water		Current Smoker	
Altered speech		Mouth ulcers		Dark/ reddish urine/ Kidney Problem		Ischemic Heart Disease	
Insomnia		Wheezing / asthma		I worry about my appearance		Stroke	
Daytime drowsiness		Cough / shortness of breath		Lost Height		Irregular Heart beats	
Visual disturbance		Chest pain		Had a recent fracture		Diabetes Mellitus	
Double vision/ squint		Feeling Sickly / Nausea		Falls Risk Assessment		The section below is for official use. Please do not tick	
Change in the look of your face		Dry Eye		Loss of your balance			
Problems with hearing		Dry Mouth		Problems with your sight		ESR:	CRP:
Persistent headache		Fever		Weakness of your grip strength		WCC:	Plt:
Migraine		Pulmonary Embolism / DVT		>1 Fall in the last year		SLEDAI:	BMI:
Finger ulcers/gangrene/dark spots		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

mRAI

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.: