Patient Reported Outcome Measures for Spondyloarthritis (AS, Psoriasis, IBD)

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:

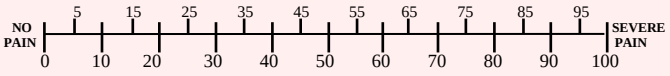
Fn. Disability

Over the LAST WEEK, were you able to	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	Unable TO DO
1. Drink from a glass	.....	.....	.....	.....
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. Walk outdoors on flat ground including crossing the road	.....	.....	.....	.....
6. Go up 2 or more flights of stairs	.....	.....	.....	.....
7. Play with / look after children	.....	.....	.....	.....
8. Do outside work (such as DIY/ gardening/ lifting)	.....	.....	.....	.....
9. Lie down / sleep on your back	.....	.....	.....	.....
10. Turn your head whilst reversing your car or use the rear view mirror?	.....	.....	.....	.....

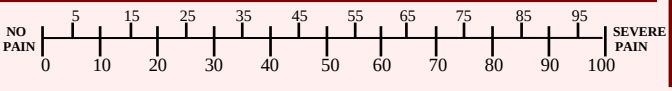
QoL

					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 SPINE PAIN have you had OVER THE PAST WEEK?



2. How much JOINT PAIN have you had OVER THE PAST WEEK?

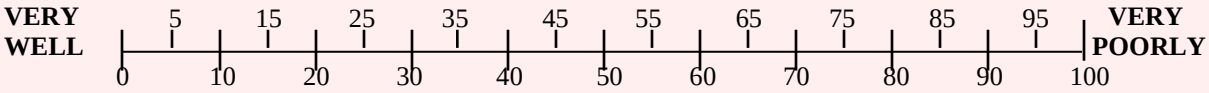


Sp. Pain

J. Pain

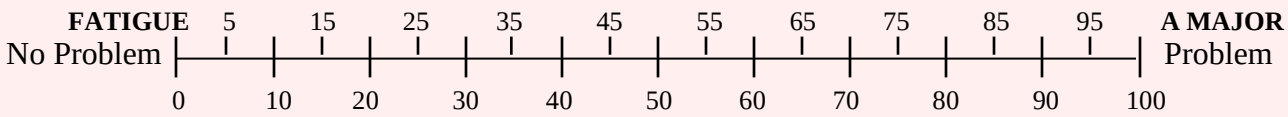
3. Considering all the ways your Disease may be affecting you AT THIS TIME Please put a circle around the number that best indicates how well you are doing:

PGA

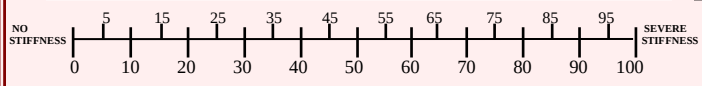


4. How much of a problem has UNUSUAL FATIGUE or tiredness been for you OVER THE PAST WEEK? (please put a circle around the number that best indicates your fatigue)

Fatigue



5. OVER THE PAST WEEK how would you rate the severity of your morning stiffness?



OVER THE PAST WEEK for how long (min./hours) did you feel stiff in the morning?

MS

El Miedany et al, Joint Bone Spine 2010; 77(6): 575

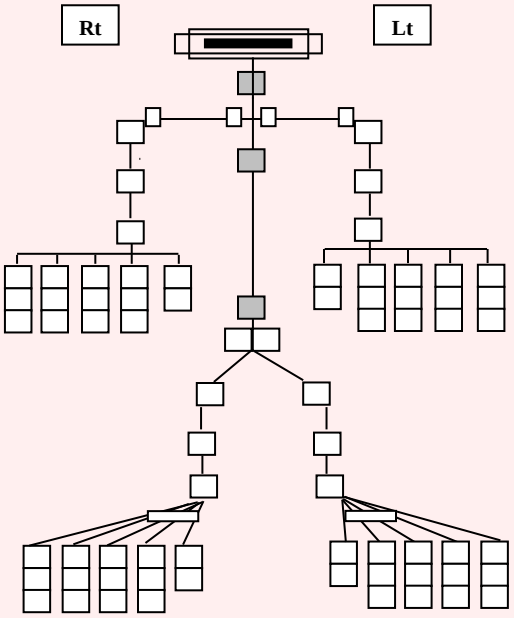
Right	Left
Upper Limb	
Tip of the Shoulder	Tip of the Shoulder
Outer side of the Arm	Outer side of the Arm
Outer/ inner side of the elbow	Outer/ inner side of the elbow
Lower Limb	
Outer Hip Area	Outer Hip Area
Front of the knee	Front of the knee
Back of the ankle	Back of the ankle
Heel	Heel
Jaw	
Jaw (Rt.)	Jaw (Lt.)
Trunk	
Neck	Chest
Upper Back	Abdomen
Lower Back	Other:

Please place (√) at the most painful area(s) over your body which you feel painful TODAY.

Enthesitis score

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

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

Fever		Dry Eye		Vertebral Fracture(s)		Cardiovascular Risk Assessment	
Weight gain (> 10 lbs)		Dry Mouth		Weakness/Paralysis of arms or legs		Age > 50 years old	
Weight Loss (> 10 lbs)		Pain in the eye / photophobia		Numbness or tingling		High Blood pressure	
Night Sweat		Headache		Muscle pain, ache or cramps		High Cholesterol	
Loss of appetite		Wheezing in the chest		Problems with thinking/memory		Current Smoker	
Soreness in the mouth		Cough		Absent from work due to spine pain		ischemic heart Disease	
Genital Ulcers		Blood in your Phlegm		Short plans for having a baby		Stroke	
Skin Rash		Shortness of breath		Sexual relationship Problems		Irregular Heart Beats	
Psoriasis		Heartburn		Problems with erection (for men)		Diabetes Mellitus	
Painful Swollen finger/ toe		Dark or bloody stools		Falls Risk Assessment		The section below is for official use. Please do not tick	
Change color/ thickening of your nail		Feeling Sickly / Nausea		>1 Fall in the last year			
Inflammatory bowel Disease		Constipation		Problems with your sight		SJC:	Chol:
Heart Valve lesion		Diarrhea		Loss of your balance		BMI:	BP: /
Problems with hearing		Problems with urination		Change in Gait / Walking Speed		ASDAS:	PASI: /72
Ringing in the ears		> 3 Alcoholic drinks per day		Weakness of your grip strength		ESR:	CRP:

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.: