The Arthritis Research Center
National Data Bank for Rheumatic Disease

ARTHRITIS RESEARCH PROJECT

Phase 68

Date you completed this questionnaire:

☐☐ / ☐☐ / ☐☐☐☐

(mm/dd/yyyy)

FOR OFFICE USE ONLY

Date Received:

☐☐ / ☐☐ / ☐☐☐☐

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SQ 68 Qtype: 20 20150101

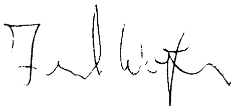
January 2015,

For those of you who are new to our questionnaire, or are returning after some time away, we welcome you. We encourage you to read through the instructions below. They will help to make the time you spend filling out the questionnaire worthwhile for both you and us. You will need to complete EACH page of the survey so we can get your historical information as well as your current information.

Please note that most questions pertain to the time frame of July 1, 2014 to December 31, 2014, unless otherwise noted. Each of you makes a valued contribution to this work. Sometimes people think that their disease is too mild, or too severe, or they aren't taking medication, or some other reason that we might not want them to continue in the study. Nothing could be further from the truth. We need the experience of each of you to further refine and develop this data bank, which continues to be the largest and most comprehensive in the world. We appreciate each and every one of you!

As always, if you need help with your questionnaire, or have a question, call us at 1-800-323-5871 and then follow the instructions and we will be glad to speak with you. You may also fill out the questionnaire online by going to www.ndb.org.

Best Wishes and very sincerely yours,



Fred Wolfe, MD

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.

3. You will also see some boxes that look like this:

   For optimum accuracy, please print carefully and avoid contact with the edges of the box. The following will serve as an example:

0	1	2	3	4	5	6	7	8	9

   Please--no fractions or decimals!!

4. If more space is needed for any question, please use the comment area on page 13.

5. You will also see some scales like the one below. You will need to make a mark in the box that best corresponds to your answer. These scales are usually 0-100. Read carefully to determine what the question is asking. In this example, the box marked with an X represents a person having a great deal of pain.

   0 — 100

   NO PAIN ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☒ ☐ ☐ SEVERE PAIN

2301

BACKGROUND AND MEDICAL HISTORY

Current marital status? *(check one)*
☐ Never Married ☐ Separated ☐ Widowed ☐ Remarried after divorce
☐ Married ☐ Divorced ☐ Remarried after death of spouse

Do you smoke cigarettes? ☐ Never ☐ Now ☐ In the Past
If you smoked in the past or currently smoke: How many years? ☐☐ How many packs per day? ☐

What is your current occupation? ____________________
(Please be specific. For example, math teacher, civil engineer, medical sales.)

Over your working life what was/is your main occupation? ____________________
(Again, please be specific.)

Currently, what is your **main** form of work? *(mark only one)* ☐ Paid Work ☐ Housework ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Were you working for pay during the time you had your arthritis or pain problem? ☐ Yes ☐ No

Did you ever stop working permanently or retire early because of your arthritis or other pain? ☐ Yes ☐ No

Did you ever stop working permanently or retire early because of another medical reason? ☐ Yes ☐ No

If yes, in what year? ☐☐☐☐

Which income group below comes closest to your total household income in the last year (**January-December 2014**) from ALL SOURCES BEFORE TAXES?
☐ Under $10,000 ☐ $10,000 - 19,999 ☐ $20,000 - 29,999 ☐ $30,000 - 39,999 ☐ $40,000 - 49,999
☐ $50,000 - 59,999 ☐ $60,000 - 69,999 ☐ $70,000 - 79,999 ☐ $80,000 - 89,999 ☐ $90,000 - 99,999
☐ $100,000 - 149,999 ☐ $150,000 or more

In your lifetime have you **EVER** received Social Security **Disability** (Medicare disability) payments? ☐ Yes ☐ No
This is NOT the same as Social Security retirement. This is a payment because you are disabled.

If yes, what was the first year you received these payments? ☐☐☐☐ Was this due to arthritis? ☐ Yes ☐ No

Now, during the time period **July 1 and December 31, 2014** did you receive any type of disability payments? ☐ Yes ☐ No

If yes, please complete the section below.

Source of Disability Payment	Due to any reason?	Due to Arthritis?
Long term disability from employment	☐ Yes ☐ No	☐ Yes ☐ No
Social security disability payments or Medicare disability payments	☐ Yes ☐ No	☐ Yes ☐ No

COMMON HEALTH PROBLEMS

Please put an X in the first column if you have this problem now. If you have had the problem in the past, put an X in the second column.

Health Problem	I had this problem in the last 6 months	I had this problem in the past	Health Problem	I had this problem in the last 6 months	I had this problem in the past
High Blood Pressure	☐	☐	Cataract	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐
Other Heart Condition	☐	☐	Severe Allergies	☐	☐
Stroke	☐	☐	Liver problem	☐	☐
Depression	☐	☐	Gallbladder problem	☐	☐
Mental Illness	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Other stomach problems	☐	☐
Cancer	☐	☐	Neurological problem (like seizures, Parkinson's disease, multiple sclerosis, etc.)	☐	☐
Alcohol or drug problem	☐	☐	Fractures of the spine/hip/leg	☐	☐
Kidney problem	☐	☐	Thyroid or endocrine disorder	☐	☐
Lung problem	☐	☐	Problems with prostate (men) Uterus, ovaries, etc. (women)	☐	☐

MEDICAL CONDITIONS & HISTORY

The following questions ask about current medical conditions.

1. Do you currently have any of the following lung problems?

Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic bronchitis	☐ Yes	☐ No
Chronic obstructive pulmonary disease (COPD)	☐ Yes	☐ No
Pulmonary Hypertension	☐ Yes	☐ No

2. Please answer the following questions **whether or not** you have a lung problem. Check "not applicable" if you can't do the activity because of physical problems, not breathing problems.

I only get breathless with strenuous exercise.	☐ Yes	☐ No	☐ Not applicable
I get short of breath when hurrying on a level or up a slight hill.	☐ Yes	☐ No	☐ Not applicable
I walk slower than people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level.	☐ Yes	☐ No	☐ Not applicable
I stop for breath after walking 100 yards or after a few minutes on the level.	☐ Yes	☐ No	☐ Not applicable
I am too breathless to leave the house.	☐ Yes	☐ No	☐ Not applicable

3. Do you **currently** take an aspirin or baby aspirin a day for your heart? ☐ Yes ☐ No

The following sections ask about medical conditions between July 1, 2014 and December 31, 2014.

Cancer

Between **July 1 and December 31, 2014** were you told that you had any kind of cancer or malignancy? ☐ Yes ☐ No
(Please list ALL of the types of cancer diagnosed between July and December on the lines below. For example: leukemia, lymphoma, lung, skin, breast, etc.)

1. ______________ 2. ______________ 3. ______________

Lungs

Between **July 1 and December 31, 2014** were you treated for:

A pulmonary embolism or blood clot in your lungs?	☐ Yes	☐ No
Fluid around your lung (pleural effusion)?	☐ Yes	☐ No
Fibrosis of the lung?	☐ Yes	☐ No

Between **July 1 and December 31, 2014**:

Were you diagnosed for the FIRST TIME with Tuberculosis (TB):	☐ Yes	☐ No
Did you have a TB skin test in the last year?	☐ Yes	☐ No

Cardiovascular (Heart) Including Stroke, Heart Attack, TIA, Irregular Heartbeats, High Blood Pressure, etc.

Between **July 1 and December 31, 2014** did you have or were you treated for :

Stroke	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
TIA (Transient Ischemic Attacks/Episodes)	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Heart Rhythm-Too Fast	☐ Yes	☐ No
Heart Attack/ Myocardial Infarction (MI)	☐ Yes	☐ No	Heart Rhythm-Too Slow	☐ Yes	☐ No
			Heart Rhythm-Irregular	☐ Yes	☐ No

Between **July 1 and December 31, 2014**:

Did you have a blood clot (phlebitis, deep vein thrombosis or DVT) in your arms or legs?	☐ Yes	☐ No
Did you notice any swelling (edema) of your body parts that was not due to arthritis?	☐ Yes	☐ No
Did you become aware of any increase in your blood pressure?	☐ Yes	☐ No
Did you have any problem controlling your high blood pressure?	☐ Yes	☐ No

The following sections ask about medical conditions between July 1, 2014 and December 31, 2014.

Renal

Between **July 1, 2014 and December 31, 2014** did you have or were you treated for:

Renal or Kidney Failure ☐ Yes ☐ No

Skin

Between **July 1, 2014 and December 31, 2014** did you have or were you treated for:

Psoriasis	☐ Yes	☐ No
Shingles (Herpes Zoster)	☐ Yes	☐ No
Cold sore (Herpes Simplex)	☐ Yes	☐ No
Human papillomavirus (Genital warts)	☐ Yes	☐ No

Liver

Between **July 1, 2014 and December 31, 2014** did you have or were you treated for:

Liver problems ☐ Yes ☐ No

Stomach

Between **July 1, 2014 and December 31, 2014** did you have or were you treated for :

- An ulcer (a stomach or duodenal ulcer)? ☐ Yes ☐ No

  If yes, which of the following did your physician use to diagnose your ulcer? (Mark all that apply)

  ☐ X-ray ☐ Endoscopy ☐ Talking to you about your symptoms

- Helicobacter pylori or H. Pylori, a stomach bacteria? ☐ Yes ☐ No

MS and Lupus

Between **July 1, 2014 and December 31, 2014** did you have or were you treated for:

- Multiple Sclerosis (MS)? ☐ Yes ☐ No

  If you had Multiple Sclerosis (MS) **before July 1, 2014** did the problems get better, get worse or stay the same?

  ☐ Get Better ☐ Get Worse ☐ Stay the Same

- Systemic Lupus, Lupus or any other auto immune disorder? ☐ Yes ☐ No
  (e.g. Sjogren's, Crohn's Disease, Ulcerative Colitis, Guillain Barre, thyroid disorder, etc.)?
  This does NOT include Rheumatoid Arthritis.

  If yes, what was the diagnosis? ______________________

Joint Problems

Between July 1, 2014 and December 31, 2014 did you have a total joint replacement? ☐ Yes ☐ No
If yes, please record joint replacements from July to December 2014 on page 7.

Please select all appropriate answers. ☐ Hip ☐ Knee ☐ Shoulder ☐ Other ☐ None

Not counting fractures that occured in the last 6 months, did you have any fractures in the **last 5 years**? ☐ Yes ☐ No

Between July 1, 2014 and December 31, 2014 did you have joint resurfacing (not a joint replacement)? ☐ Yes ☐ No

15272

The following sections ask about medical conditions between July 1 and December 31, 2014.

INFECTIONS

Did you have any infections from **July 1 and December 31, 2014**? ☐ Yes ☐ No — If "yes" please answer section directly below.

Type of Infection - please place an X next to the type of infection that you had between July 1 and December 31, 2014.	Number of these infections you had between July 1 and December 31, 2014.	Did you receive intravenous antibiotics (given in the vein) for this infection?	Were you hospitalized for this infection? (Be sure to mark any hospitalizations on page 9)
☐ Septicemia (sepsis, blood stream infection)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Pneumonia, coccidiomycosis or other lung infection (not bronchitis or upper respiratory infections, ie. not "colds".)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Pneumocystis, histoplasmosis, cytomegalic infections, blastomycosis, lysteria or listeriosis, aspergillosis, cryptococcus, nocardia, toxoplasmosis, cryptosporidiosis or any other fungal infection (**NOT** skin or nail infections)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Skin infections (infected skin ulcer, cellulitis, infected nodules)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Urinary tract infection / Kidney infection / Bladder infection	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Bone/Joint infection (osteomyelitis, septic joint, infected artificial joint)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Influenza (Flu)	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Bronchitis	☐ 1 ☐ 2 ☐ 3+	☐ Yes ☐ No	☐ Yes ☐ No
☐ Tuberculosis (TB)	☐ 1 ☐ 2 ☐ 3+		☐ Yes ☐ No
☐ Cold or Upper respiratory illness (URI), sinusitis	☐ 1 ☐ 2 ☐ 3+		☐ Yes ☐ No
☐ Other, please specify ______________	☐ 1 ☐ 2 ☐ 3+		☐ Yes ☐ No

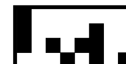
If you were hospitalized during July 1 and December 31, 2014, did you develop an infection while you were in the hospital or during the 30 days after you were hospitalized? ☐ Yes ☐ No

During the past 7 days, how much have you been bothered by any of the following problems?

	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. Stomach or bowel problems	☐	☐	☐	☐	☐
2. Back pain	☐	☐	☐	☐	☐
3. Pain in your arms, legs, or joints	☐	☐	☐	☐	☐
4. Headaches	☐	☐	☐	☐	☐
5. Chest pain or shortness of breath	☐	☐	☐	☐	☐
6. Dizziness	☐	☐	☐	☐	☐
7. Feeling tired or having low energy	☐	☐	☐	☐	☐
8. Trouble sleeping	☐	☐	☐	☐	☐

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Little interest or pleasure in doing things	☐	☐	☐	☐
4. Feeling down, depressed or hopeless	☐	☐	☐	☐



The following section ask whether you EVER had Hepatitis or Joint Replacements.

Have you **EVER:**

Been diagnosed with Hepatitis A, B, or C? ☐ Yes ☐ No ☐ Don't know

If yes, what type? ☐ A ☐ B ☐ C ☐ I had hepatitis but don't know the type

Had a total joint replacement of the hip, knee or shoulder? ☐ Yes ☐ No

If yes, what was the year of the first surgery? ☐☐☐☐

What is the number of total joint replacement surgeries you have had (please check all that apply).

Hip	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ More than 4
Knee	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ More than 4
Shoulder	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ More than 4
Other	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ More than 4

If you are stiff in the morning, about how long does the stiffness last?

☐ No stiffness ☐ Less than 30 min ☐ 30 min - 1 hr ☐ 1-2 hrs ☐ 2-4 hrs ☐ 4-8 hrs ☐ More than 8 hrs

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 0-100.

NO PAIN **0** ☐ **100** SEVERE PAIN

In general, would you say that your HEALTH NOW is: ☐ Excellent ☐ Good ☐ Fair ☐ 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**	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
Reach and get down a 5 pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Go up two or more flights of stairs?	☐	☐	☐	☐
Do yard work (outside work or activities)?	☐	☐	☐	☐
Move heavy objects (such as furniture)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐

How satisfied are you with your HEALTH NOW?

☐ Very satisfied ☐ Somewhat satisfied ☐ Neither satisfied nor dissatisfied ☐ Somewhat dissatisfied ☐ Very dissatisfied

JOINT/BODY PAIN

Please indicate below the amount of pain and/or tenderness you have had over THE PAST 7 DAYS in each of the joint and body areas listed below. Please make an X in the box that best describes your pain or tenderness. Be sure to mark both right side and left side separately. If you have had no pain or tenderness in a particular joint or body part, mark "None." *There should be an answer for every joint or body part listed.*

JOINTS	None	Mild	Mod	Severe	OTHER BODY AREAS	None	Mild	Mod	Severe
Shoulder, Lt.	☐	☐	☐	☐	Jaw, Lt.	☐	☐	☐	☐
Shoulder, Rt.	☐	☐	☐	☐	Jaw, Rt.	☐	☐	☐	☐
Elbow, Lt.	☐	☐	☐	☐	Lower Back	☐	☐	☐	☐
Elbow, Rt.	☐	☐	☐	☐	Upper Back	☐	☐	☐	☐
Wrist, Lt.	☐	☐	☐	☐	Neck	☐	☐	☐	☐
Wrist, Rt.	☐	☐	☐	☐					
Hand knuckles, Lt.	☐	☐	☐	☐	Upper arms, Lt.	☐	☐	☐	☐
Hand knuckles, Rt.	☐	☐	☐	☐	Upper arms, Rt.	☐	☐	☐	☐
Finger knuckles, Lt.	☐	☐	☐	☐	Lower arms, Lt.	☐	☐	☐	☐
Finger knuckles, Rt.	☐	☐	☐	☐	Lower arms, Rt.	☐	☐	☐	☐
Hip, Lt.	☐	☐	☐	☐	Upper leg, Lt.	☐	☐	☐	☐
Hip, Rt	☐	☐	☐	☐	Upper leg, Rt.	☐	☐	☐	☐
Knee, Lt.	☐	☐	☐	☐	Lower leg, Lt.	☐	☐	☐	☐
Knee, Rt.	☐	☐	☐	☐	Lower leg, Rt.	☐	☐	☐	☐
Ankle, Lt.	☐	☐	☐	☐	Head	☐	☐	☐	☐
Ankle, Rt.	☐	☐	☐	☐	Chest	☐	☐	☐	☐
Ball of foot, Lt.	☐	☐	☐	☐	Abdomen	☐	☐	☐	☐
Ball of foot, Rt.	☐	☐	☐	☐					
Heel, Lt.	☐	☐	☐	☐					
Heel, Rt.	☐	☐	☐	☐					
Foot arch, Lt.	☐	☐	☐	☐					
Foot arch, Rt.	☐	☐	☐	☐					

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 0-100.

VERY WELL **0** ☐ **100** VERY POOR

In general, how active was your arthritis or fibromyalgia from **July 1, 2014 and December 31, 2014**? Place an X in the box below to indicate the amount of activity on a scale of 0-100.

NOT ACTIVE AT ALL **0** ☐ **100** EXTREMELY ACTIVE

In terms of joint tenderness and swelling, how active is your arthritis or fibromyalgia **TODAY**? Place an X in the box below to indicate the amount of tenderness and swelling on a scale of 0-100.

NOT ACTIVE AT ALL **0** ☐ **100** EXTREMELY ACTIVE

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 0-100.

FATIGUE IS NO PROBLEM **0** ☐ **100** FATIGUE IS A MAJOR PROBLEM

HOSPITALIZATIONS

PLEASE DO NOT LEAVE THIS PAGE BLANK!

Did you stay in the hospital overnight for any reason between July 1 and December 31, 2014? ☐ **Yes** ☐ **No**
If yes, please list all of those below.

Reason for Hospitalization	Hospital Name, City, State	Month Admitted	Number of nights in the hospital	Type of Stay: Medical	Type of Stay: Surgical
1)		☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ 1 ☐ 2-3 ☐ 4-6 ☐ 7-13 ☐ 14 or more	☐	☐
2)		☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ 1 ☐ 2-3 ☐ 4-6 ☐ 7-13 ☐ 14 or more	☐	☐
3)		☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ 1 ☐ 2-3 ☐ 4-6 ☐ 7-13 ☐ 14 or more	☐	☐
4)		☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ 1 ☐ 2-3 ☐ 4-6 ☐ 7-13 ☐ 14 or more	☐	☐

Between July 1 and December 31, 2014, have you been to a hospital emergency room (ER)? (Do not include after-hours clinics or urgent care centers) ☐ **Yes** ☐ **No**

If yes, how many total ER visits did you have? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Between July 1 and December 31, 2014, were you a patient in a nursing or convalescent home or live-in rehabilitation center? ☐ **Yes** ☐ **No**

If yes, how many days did you spend in that center? ☐ 1-7 ☐ 8-14 ☐ 15-21 ☐ 22-28 ☐ More than 28

Between July 1 and December 31, 2014, have you had any outpatient surgery, endoscopy, gastroscopy or biopsy procedures? ☐ **Yes** ☐ **No**
If yes, please list all of those below:

Surgery/Procedure	Doctor's Name	Location and Address of Hospital or Doctor's Office	Month Procedure Done	Type of Procedure: Medical	Type of Procedure: Surgical
1)			☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐	☐
2)			☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐	☐
3)			☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐	☐

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MEDICATIONS

We are interested in ALL of the medicine you have taken in the PAST 6 MONTHS (**July 1 to December 31, 2014**).
This includes both prescription and non-prescription medicines that you take for a health problem or to prevent a health problem.
This includes: your arthritis and pain-relieving medicines; stomach medicines; heart medicines; blood pressure medicines; cholesterol, insulin; hormones; topicals/creams; medicine for a headache or a "cold"; and "health food" type supplements like vitamins, herbs, and minerals. This would include things like glucosamine and chondroitin. In other words, all medications!

- **SPECIAL INSTRUCTIONS ABOUT INJECTIONS:** Include ALL injectable and infusion medications including Remicade, Humira, Enbrel, Kineret, Methotrexate, Rituxan, Orencia, Cimzia, Simponi, Actemra, Cortisone, Aristocort, Gold, Hyalgan, Synvisc, Prosorba treatments, Forteo, insulin and pain blocks.

  1. Place the injection size or the strength of the injection (if you know it) in the "Average Pill Strength" column. For example, for Methotrexate you might write .6 ml or .6 cc (injection size) or 15 mg (the strength).

  2. In the "Pills used per day" column tell us how often you take the injections if taken on a regular basis. Here are some examples that would work: 2 per week
     3 per month
     1 every 8 weeks
     1 every 4 months

  Write in the number of injections AND the time period as shown above that best describes how you receive your injections.

- Include your arthritis medicines like Arava, Celebrex, Prednisone, Methotrexate (MTX), Gold, Plaquenil, Daypro, Etodolac, Relafen, Ibuprofen, and Naprosyn. **For oral Methotrexate (MTX) please indicate the number of pills used per week instead of per day.**

- Since some arthritis medicines may bother your stomach, please tell us about any stomach medicines that you take like Prevacid, Pepcid, Prilosec, Zantac, Tagamet, Tums, etc.

- Be sure to include medicines like Aspirin and Acetaminophen (Tylenol), or any medicines that contain Aspirin or Acetaminophen (Tylenol). When recording Aspirin, please tell us what type it is: for example, regular, enteric coated, buffered, etc.

- Also include pain medications like Ultram and medicines like vitamin D, calcium, fluoride, estrogens, and osteoporosis drugs.

- If you are taking Methotrexate please indicate if it's a pill or an injection by writing "Methotrexate pill" or "Methotrexate Inj.".

Pages 8, 9 and 10 are for you to write in oral and injectable prescriptions and medicines.

If you had a side effect to any medicine you have taken between **July 1 to December 31, 2014**, please be sure to give us the details about that side effect on page 11 and 12. Also, if you stopped taking a medication, tell us why on page 12.

Mark here if you took NO medications from July - December 2014: ☐

Medicines Taken from July 1 - December 31, 2014

Drug Name ***If injection see special instructions above** **Please Print**	**Is this a prescrip-tion?**	**Average Pill Strength** **For Injections see instructions**	**Average days used per month?**	**Pills Used Per Day** **For Injections see instructions**	**Check any month used, even if only for one day**	**Were you still taking as of 12/31/14? (If no, see pg 12)**	**Did you start this medicine between July 1 and December 31, 2014?**	**Did you have a side effect to this medicine? (If yes, see pg 11 & 12)**
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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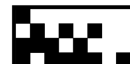

DRUGS CONTINUED JULY 1- DECEMBER 31, 2014

Drug Name *If injection see special instructions on pg 8. Please Print	Is this a prescrip-tion?	Average Pill Strength For Injections see instructions	Average days used per month?	Pills Used Per Day For Injections see instructions	Check any month used, even if only for one day	Were you still taking as of 12/31/14? (If no, see pg 12)	Did you start this medicine between July 1 and December 31, 2014?	Did you have a side effect to this medicine? (If yes, see pg 11 & 12)
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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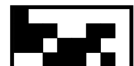

DRUGS CONTINUED JULY 1- DECEMBER 31, 2014

Drug Name *If injection see special instructions on pg 8. Please Print	Is this a prescrip-tion?	Average Pill Strength For Injections see instructions	Average days used per month?	Pills Used Per Day For Injections see instructions	Check any month used, even if only for one day	Were you still taking as of 12/31/14? (If no, see pg 12)	Did you start this medicine between July 1 and December 31, 2014?	Did you have a side effect to this medicine? *(If yes, see pg 11 & 12)*
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No		☐ 1-10 ☐ 11-20 ☐ 21-31		☐ All ☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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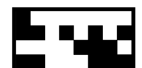

Drug Side Effects You Experienced between July 1 and December 31, 2014

We now need some additional information about any side effects that you marked on pages 8-10. Below and on the next page are spaces for side effects to three separate drugs. If you need more room, just write us a note and include it with this form when you send it back to us.

Drug causing side effect: 1) ______________________

Did you STOP the drug because of a side effect? ☐ Yes ☐ No

Did you change the dosage of the drug because of a side effect? ☐ Yes ☐ No

What side effects did you experience? Please list. — How SEVERE was each side effect?

1. ______________________ ☐ Mild ☐ Moderate ☐ Severe
2. ______________________ ☐ Mild ☐ Moderate ☐ Severe
3. ______________________ ☐ Mild ☐ Moderate ☐ Severe

Because of these side effects, did you have to: (mark all that apply) ☐ Take additional medicine ☐ Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

☐ No time lost ☐ 1-3 days ☐ 4-7 days ☐ 8-10 days ☐ 11-20 days ☐ 21-30 days ☐ More than 30 days

What was the month that you first began experiencing the side effect(s) to this drug? ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Do you still have any of these side effects? ☐ Yes ☐ No

About how long did the side effects last?

☐ Less than 1 week ☐ 1-3 wks ☐ 3-4 weeks ☐ 1-2 months ☐ 2-3 months ☐ 3-4 months ☐ 4-5 months ☐ 5-6 months

How certain are you that the above drug caused the side effects you described? ☐ Very certain ☐ Fairly certain ☐ A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer? ☐ Yes ☐ No *(Be sure to mark any hospitalizations on page 7)*

Drug causing side effect: 2) ______________________

Did you STOP the drug because of a side effect? ☐ Yes ☐ No

Did you change the dosage of the drug because of a side effect? ☐ Yes ☐ No

What side effects did you experience? Please list. — How SEVERE was each side effect?

1. ______________________ ☐ Mild ☐ Moderate ☐ Severe
2. ______________________ ☐ Mild ☐ Moderate ☐ Severe
3. ______________________ ☐ Mild ☐ Moderate ☐ Severe

Because of these side effects, did you have to: (mark all that apply) ☐ Take additional medicine ☐ Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

☐ No time lost ☐ 1-3 days ☐ 4-7 days ☐ 8-10 days ☐ 11-20 days ☐ 21-30 days ☐ More than 30 days

What was the approximate month that you first began experiencing the side effect(s) to this drug? ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Do you still have any of these side effects? ☐ Yes ☐ No

About how long did they last?

☐ Less than 1 week ☐ 1-3 wks ☐ 3-4 weeks ☐ 1-2 months ☐ 2-3 months ☐ 3-4 months ☐ 4-5 months ☐ 5-6 months

How certain are you that the above drug caused the side effects you described? ☐ Very certain ☐ Fairly certain ☐ A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer? ☐ Yes ☐ No *(Be sure to mark any hospitalizations on page 7)*

Continued on page 12

17182

Drug causing side effect: 3) ______________________

Did you STOP the drug because of a side effect? ☐ Yes ☐ No

Did you change the dosage of the drug because of a side effect? ☐ Yes ☐ No

What side effects did you experience? Please list.

How SEVERE was each side effect?

1. ______________________ ☐ Mild ☐ Moderate ☐ Severe
2. ______________________ ☐ Mild ☐ Moderate ☐ Severe
3. ______________________ ☐ Mild ☐ Moderate ☐ Severe

Because of these side effects, did you have to: (mark all that apply) ☐ Take additional medicine ☐ Go to a doctor

If you are employed, how much time did you lose from work because of these side effects, if any?

☐ No time lost ☐ 1-3 days ☐ 4-7 days ☐ 8-10 days ☐ 11-20 days ☐ 21-30 days ☐ More than 30 days

What was the month that you first began experiencing the side effect(s) to this drug? ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Do you still have any of these side effects? ☐ Yes ☐ No

About how long did the side effects last?

☐ Less than 1 week ☐ 1-3 wks ☐ 3-4 weeks ☐ 1-2 months ☐ 2-3 months ☐ 3-4 months ☐ 4-5 months ☐ 5-6 months

How certain are you that the above drug caused the side effects you described? ☐ Very certain ☐ Fairly certain ☐ A bit uncertain

Did the side effect(s) cause you to be hospitalized overnight or longer? ☐ Yes ☐ No *(Be sure to mark any hospitalizations on page 7)*

For any of the medicines on pages 8-10 that you stopped taking between July 1 and December 31, 2014, please give us the additional information requested below.

Name of Drugs You Stopped Please Print	Why Stopped? (X all that apply)	Month stopped in 2014	Between July 1 and Dec. 31, 2014, did you start another medicine to replace it?	If Yes, which Medicine? Please Print	Were you taking that medicine as of 12/31/14?
1.	☐ Didn't work ☐ Side effects ☐ Cost ☐ Other ______	☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	Yes ☐ No ☐		Yes ☐ No ☐
2.	☐ Didn't work ☐ Side effects ☐ Cost ☐ Other ______	☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	Yes ☐ No ☐		Yes ☐ No ☐
3.	☐ Didn't work ☐ Side effects ☐ Cost ☐ Other ______	☐ Jul ☐ Oct ☐ Aug ☐ Nov ☐ Sep ☐ Dec	Yes ☐ No ☐		Yes ☐ No ☐

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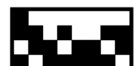

We need some information to keep our records current. We don't release this information to anyone. It is to help us keep track of you for mailing and telephone purposes.

Please list below the names and numbers of two people who don't live with you but are likely to know how to contact you.

1) Name ______________________

Area Code & Phone [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

2) Name ______________________

Area Code & Phone [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

Your Home Phone: [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

Alternate Phone Number: [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]

Spouse's first name:

Best time of day to call you:

Please enter the last 4 digits of your Social Security Number. This enables the NDB to distinguish participants with similar names and home cities. It cannot be used to identify you in any way.

E-mail address: (please print)

Please tell us the name of the doctor who is currently providing your arthritis care.

Dr. Name: ______________________

Dr. Address: ______________________

City ______________ **State** ______________ **Zip** ______________

If you have any comments, additional information or any problems that you think are important that we didn't ask about, please explain below.

RELEASE OF MEDICAL INFORMATION

This page requests permission for us to review your medical records pertaining to your involvement in this research program. This information will be kept strictly confidential and used for research purposes only.

PLEASE USE INK AND PRINT

Name: ______________________________ **Phone** ( ) __________
Last **First** **Middle**

Address: ______________________________
Street **City** **State** **Zip**

Birthdate: __________ **Age:** ______ **Social Security Number:** __________
Optional

Covering records from the period: 06/30/2014 through present. **Purpose of disclosure:** Long term outcome research in arthritis.

Information required: Any of the following with ICD coding of primary and secondary diagnoses

☐ Discharge Summary (procedure)__________ ☐ Biopsy Report (area)__________

☐ Out Patient Report (procedure)__________ ☐ Other Report (procedure) __________

I understand that the information in my health record may include information relating to communicable or noncommunicable disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

National Databank for Rheumatic Disease will not condition treatment, payment, enrollment or eligibility for benefits whether I sign the authorization.

Data from this study may be linked with data supplied by the National Center for Health Statistics, the Center for Medicare and Medicaid Services, and other administrative databases. An administrative database has information about diagnoses, medical visits and laboratory tests. Your social security number may be used to match your data in the administrative database. Your data will be kept confidential according to the Privacy Act of 1974, and will be used only for research purposes.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that this information is confidential and will be used for research purposes only.

I have carefully read the above consent form and understand and know its contents. I have signed this consent of my own free will and consider myself bound by the provisions contained in the consent. I understand that I have the right to revoke (cancel) this authorization at any time by writing to Medical Records Acquisition, National Databank for Rheumatic Diseases, 1035 N. Emporia STE 288, Wichita, KS 67214 and that it will not apply to any information released before the written revocation is received. Upon the lapse of six (6) months from the date of signature this consent will automatically expire without my express revocation.

______________________________ __________
Signature of Patient or Legal Representative **Date**

____
Relationship if not signed by Patient

______________________________ __________
Witness **Date**

Office Use

This is to authorize that medical information regarding the above identified person be released:

FROM:

____
Name of Facility to Release Information

____
Address of Facility to Release Information

TO: **Deb Molina**
The Arthritis Research Center Foundation / National Data Bank for Rheumatic Disease
1035 N Emporia STE 288
Wichita KS 67214
Phone: 316-263-2125 **FAX: 316-263-0761**

PHOTOCOPY OF THIS AUTHORIZATION SHOULD BE TREATED IN THE SAME MANNER AS THE ORIGINAL

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