BRASS PATIENT
ONE YEAR FOLLOW UP QUESTIONNAIRE

MARKING INSTRUCTIONS
- Use a No. 2 pencil or blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the circle completely.
- Make no stray marks on this form.
- Do not fold, tear, or mutilate this form.

A. GENERAL INFORMATION

A1. Current Phone Number:

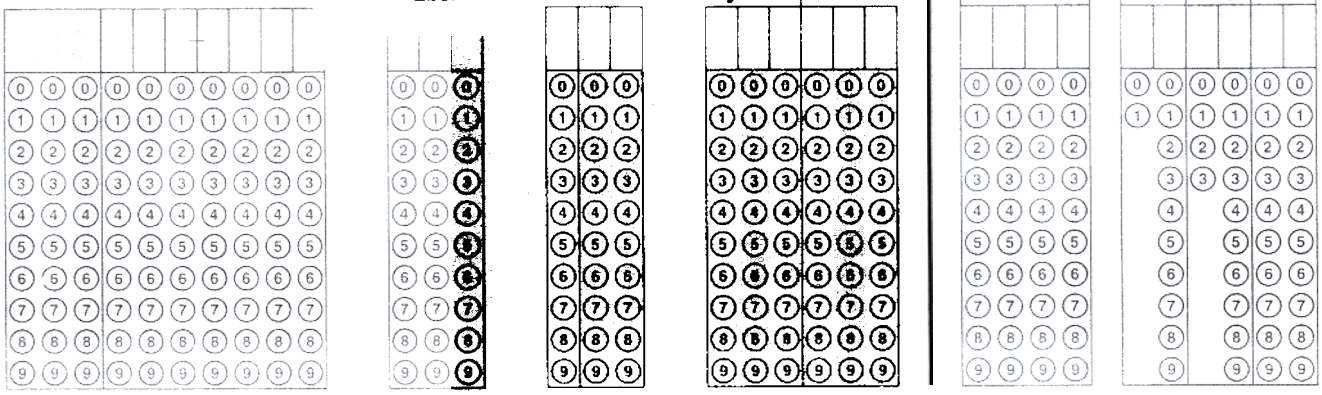
A2. Weight (Lbs.)

A3. Height (Ft. Inch)

A4. Blood Pressure (Systolic | Diastolic)

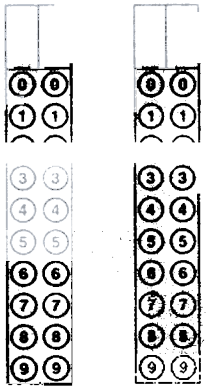
Study ID

Date (Mo. | Day | Year)



A5. Age:

A6. What was your birth order?



A7. What was your birth weight?

- ◯ I do not know my birth weight
- ◯ Less than 5 pounds
- ◯ 5 to 5.5 pounds
- ◯ 5.6 to 7 pounds
- ◯ 7.1 to 8.5 pounds
- ◯ 8.6 to 10 pounds
- ◯ More than 10 pounds

A8. Have you had any children in the past year?

- ◯ Yes
- ◯ No

A9. Did you have any of the following vaccinations BEFORE your symptoms of rheumatoid arthritis began?

	YES	NO	UNKNOWN
A9-1. Hepatitis A	◯	◯	◯
A9-2. Hepatitis B	◯	◯	◯
A9-3. Influenza	◯	◯	◯
A9-4. Pneumonia	◯	◯	◯
A9-5. Chickenpox	◯	◯	◯
A9-6. Tetanus	◯	◯	◯
A9-7. Rubella/MMR	◯	◯	◯

B. WHAT ARTHRITIS MEDICATIONS ARE YOU CURRENTLY TAKING?

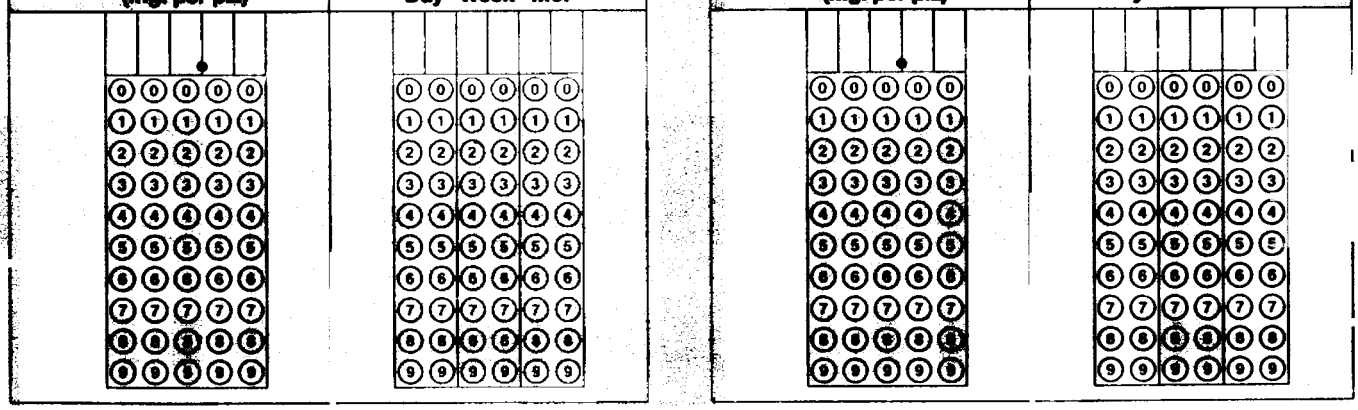
Please tell us what medications for arthritis you were taking when you arrived for your appointment TODAY.
Please do not include any changes to your medication regimen that your doctor prescribed today.

MEDICATION	YES	NO
B1. Celebrex (celecoxib)	◯	◯

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.

MEDICATION	YES	NO
B2. Vioxx (rofecoxib)	◯	◯

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



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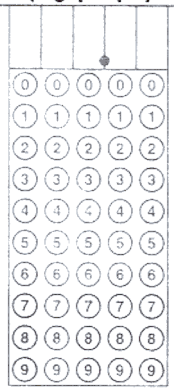
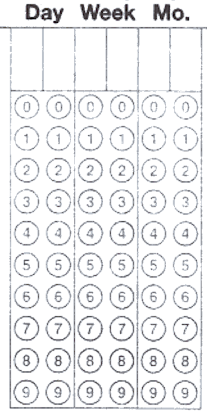
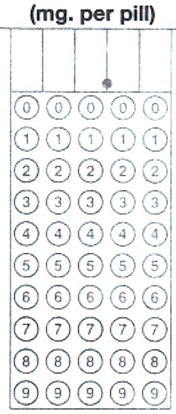
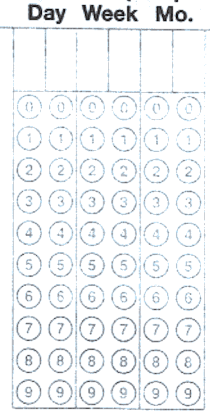
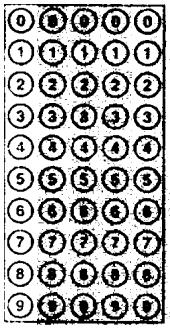
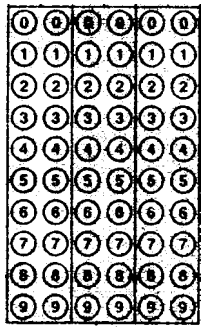
MEDICATION	YES	NO
B3. Bextra (valdecoxib)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

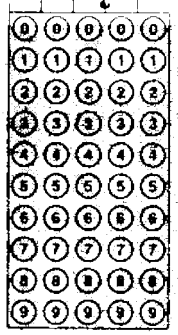
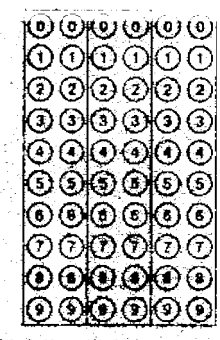
MEDICATION	YES	NO
B6. Deltasone (prednisone)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

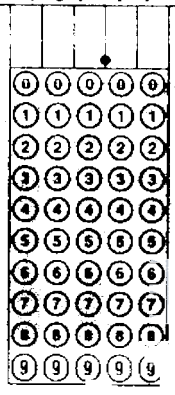
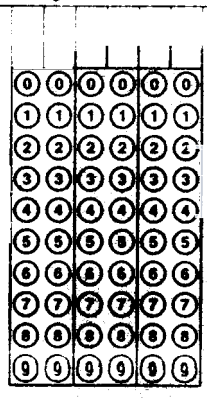
MEDICATION	YES	NO
B4. Motrin (ibuprofen)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

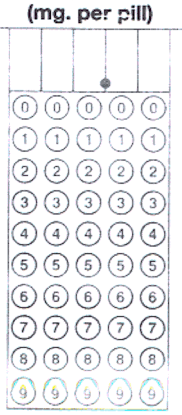
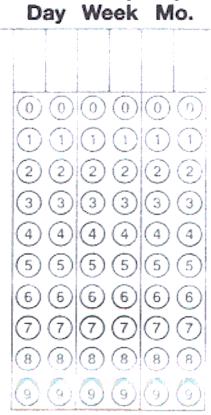
MEDICATION	YES	NO
B7. Medrol (methylprednisolone)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

MEDICATION	YES	NO
B5. Aleve (naproxen)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

MEDICATION	YES	NO
B8. Plaquenil (hydroxychloroquine)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
	

MEDICATION	YES	NO
B9. Methotrexate ○ PO ○ Inj	○	○

STRENGTH (mg. per inj.)	FREQUENCY Number of inj. per Day Week Mo.

MEDICATION	YES	NO
B12. Enbrel (etanercept)	○	○

STRENGTH (mg. per med)	FREQUENCY Infusion per Day Week Mo.

MEDICATION	YES	NO
B10. Azulfidine (sulfasalazine)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.

MEDICATION	YES	NO
B13. Remicade (infliximab)	○	○

STRENGTH (mg. per med)	FREQUENCY Infusion per Day Week Mo.

MEDICATION	YES	NO
B11. Arava (leflunomide)		

STRENGTH (mg. per pill)	

MEDICATION	YES	NO
B14. Kineret (anakinra)	○	

STRENGTH (mg. per med)	FREQUENCY Infusion per Day Week Mo.

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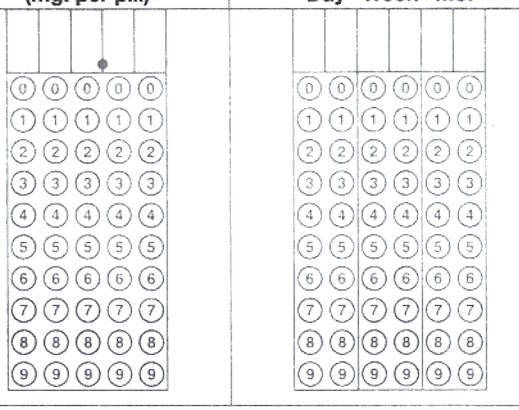
2012

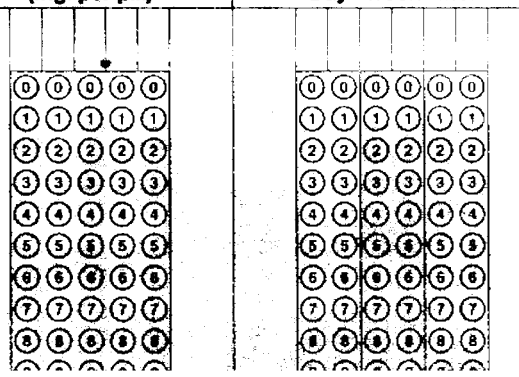
MEDICATION	YES	NO
B15. Humira (adalimumab)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



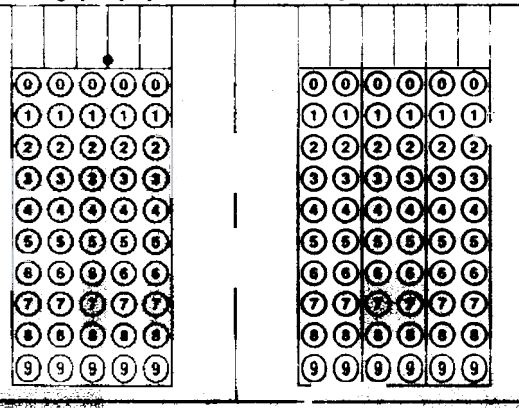
MEDICATION	YES	NO
B16. Neoral/Sandimmune (cyclosporine)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



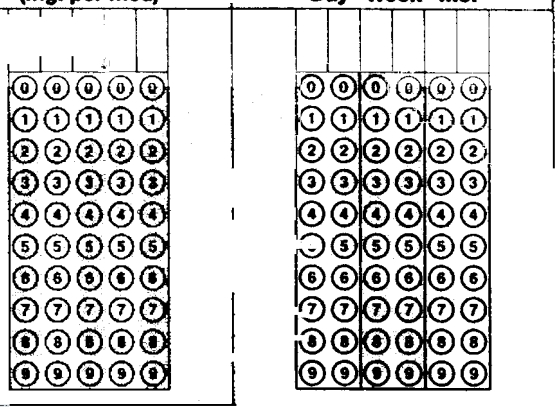
MEDICATION	YES	NO
B17. Imuran (azathioprine)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



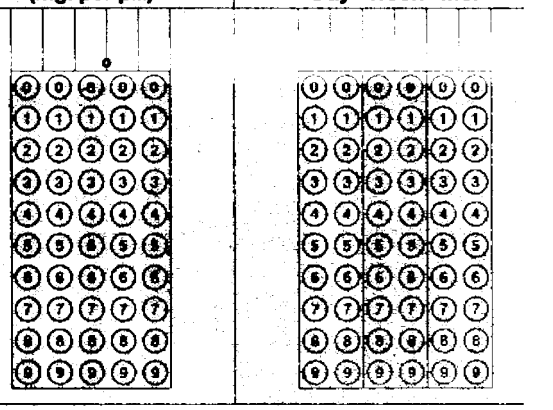
MEDICATION	YES	NO
B18. Gold/Myochrysine (aurothioglucose)	○	○

STRENGTH (mg. per med)	FREQUENCY Injection per Day Week Mo.



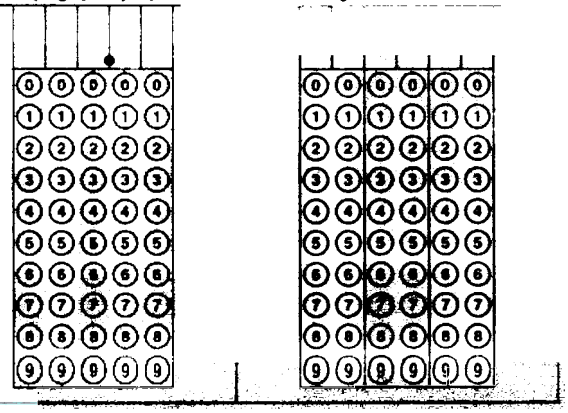
MEDICATION	YES	NO
B19. Gold/Ridaura (auranofin)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



MEDICATION	YES	NO
B20. Penicillamine (cuprimine)	○	○

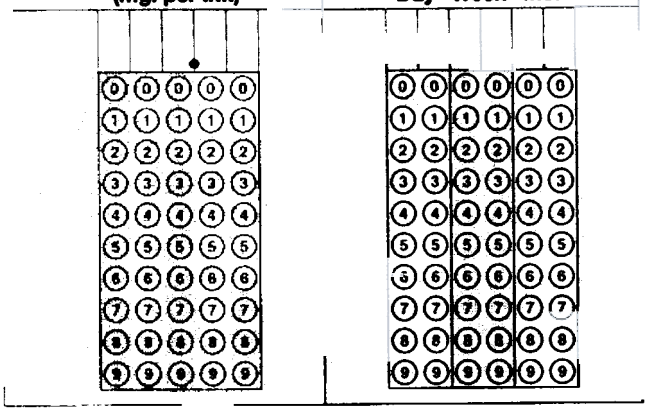
STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.



MEDICATION	YES	NO
B21. Rituximab	○	○

STRENGTH (mg. per inf.)

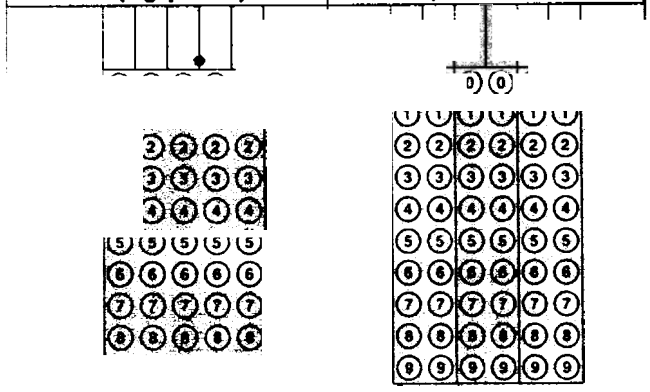
FREQUENCY Number of inf. per Day Week Mo.



MEDICATION	YES	NO
B22. Cyclophosphamide ○ PO ○ Inj	○	○

STRENGTH (mg. per inf.)

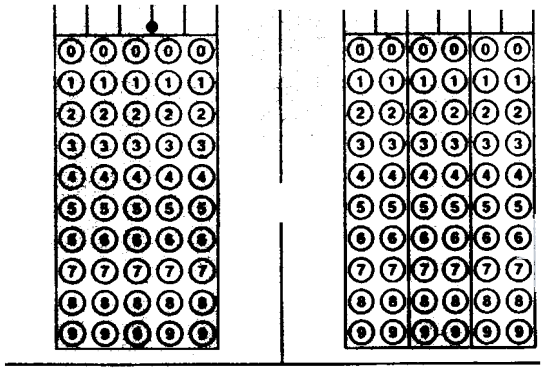
FREQUENCY Number of inf. per Day Week Mo.



MEDICATION	YES	NO
B23. Leucovorin		

STRENGTH (mg. per pill)

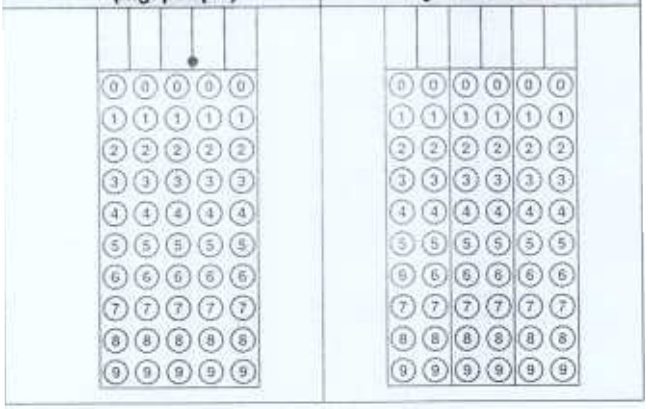
FREQUENCY Number of pills per Day Week Mo.



MEDICATION	YES	NO
B24. Aspirin	○	○

STRENGTH (mg. per pill)

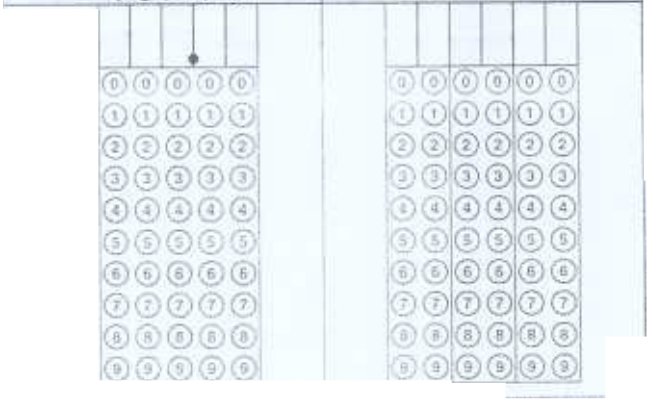
FREQUENCY Number of pills per Day Week Mo.



MEDICATION	YES	NO
B25. Other:	○	○

STRENGTH (mg. per pill)

FREQUENCY Number of pills per Day Week Mo.



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Please tell us what medications for pain you were taking when you arrived for your appointment TODAY.
Please do not include any changes to your medication regimen that your doctor prescribed today.

	YES	NO
B26. Ultram (tramadol)	○	

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B29. Fioricet	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B27. Percocet (Roxicet/Tylox)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B30. Fiorinal	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B28. OxyContin (oxycodone)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B31. Percodan	○	

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day Week Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B32. Darvocet	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B33. Darvon	○	

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B34. MS Contin	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B35. Tylenol (acetaminophen)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B36. Vicodin (hydrocodone)	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

MEDICATION	YES	NO
B37. Other:	○	○

STRENGTH (mg. per pill)	FREQUENCY Number of pills per Day	Week	Mo.
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

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B38. Have you taken prednisone or medrol pills in the PAST 6 MONTHS?

◯ YES ◯ NO (If NO, please proceed to question #C1)

→ **B38-1. IF YES, about how many weeks have you taken prednisone or medrol pills over the PAST 6 MONTHS?**

◯ 1–2 weeks ◯ 3–6 weeks ◯ 7–12 weeks ◯ 13–24 weeks

→ **B38-2. What has been your most common daily dosage of prednisone or medrol pills over the PAST 6 MONTHS?**

◯ 1–5 milligrams ◯ 6–10 milligrams ◯ 11–20 milligrams ◯ More than 20 milligrams

C. PAST MEDICATIONS FOR ARTHRITIS

Did you STOP taking any arthritis medications in the PAST 6 MONTHS?

◯ YES ◯ NO (If NO, please proceed to question #D1)

→ **Why did you stop taking these medications? How long were you taking these medications?**

Medication	Yes/No	Duration (Months)
C1. Plaquenil (hydroxychloroquine)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Don't know	Other:			
11	12			

Medication	Yes/No	Duration (Months)
C4. Arava (leflunomide)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Infection	Swelling	Stomach problem	Don't know	Other:	
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)	

Medication	Yes/No	Duration (Months)
C2. Rheumatrex (methotrexate)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Infection	Swelling	Stomach problem	Don't know	Other:	
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)	

Medication	Yes/No	Duration (Months)
C5. Enbrel (etanercept)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Infection	Swelling	Stomach problem	Don't know	Other:	
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)	

Medication	Yes/No	Duration (Months)
C3. Azulfidine (sulfasalazine)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Infection	Swelling	Stomach problem	Don't know	Other:	
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)	

Medication	Yes/No	Duration (Months)
C6. Remicade (infliximab)	1 (Y) (N)	___

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)
Infection	Swelling	Stomach problem	Don't know	Other:	
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)	

Continue on next page

Medication	Yes/No	Duration (Months)
C7. Kineret (anakinra)	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C11. Gold/Myochrysine	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C8. Humira (adalimumab)	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C12. Gold/Ridaura	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C9. Sandimmune/Neoral (cyclosporine)	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C13. Penicillamine (cuprimine)	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8 (Y) (N)	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C10. Imuran (azathioprine)	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

Infection	Swelling	Stomach problem	Don't know	Other:
8	9 (Y) (N)	10 (Y) (N)	11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)
C14. Cyclophosphamide	1 (Y) (N)	

Why did you stop taking this medication?

Not effective	Skin rash	Liver problem	Lung problem	Falling blood counts	Infusion reaction
2 (Y) (N)	3 (Y) (N)	4 (Y) (N)	5 (Y) (N)	6 (Y) (N)	7 (Y) (N)

[illegible]	Swelling		Don't know	Other:
8 (Y) (N)	9 (Y) (N)		11 (Y) (N)	12 (Y) (N)

Medication	Yes/No	Duration (Months)	Medication	Yes/No	Duration (Months)
C15. NSAID	1 (Y) (N)		C16. Other:	1 (Y) (N)	

Why did you stop taking this medication?						Why did you stop taking this medication?					
Not effective 2 (Y) (N)	Skin rash 3 (Y) (N)	Liver problem 4 (Y) (N)	Lung problem 5 (Y) (N)	Falling blood counts 6 (Y) (N)	Infusion reaction 7 (Y) (N)	Not effective 2 (Y) (N)	Skin rash 3 (Y) (N)	Liver problem 4 (Y) (N)	Lung problem 5 (Y) (N)	Falling blood counts 6 (Y) (N)	Infusion reaction 7 (Y) (N)
Infection 8 (Y) (N)	Swelling 9 (Y) (N)	Stomach problem 10 (Y) (N)	Don't know 11 (Y) (N)	Other: 12 (Y) (N)		Infection 8 (Y) (N)	Swelling 9 (Y) (N)	Stomach problem 10 (Y) (N)	Don't know 11 (Y) (N)	Other: 12 (Y) (N)	

D. CURRENT NON-ARTHRITIS MEDICATIONS

D1. What vitamins and/or minerals are you CURRENTLY taking?

- ○ None
- ○ Multivitamin (any kind)
- ○ Vitamin B
- ○ Vitamin C
- ○ Vitamin D
- ○ Vitamin E
- ○ Calcium
- ○ Iron
- ○ Folic Acid
- ○ Vitamin B-6
- ○ Vitamin B-12
- ○ Magnesium
- ○ Other: _____
- ○ Other: _____

D2. What herbal/health food preparations are you CURRENTLY taking for your arthritis?

- ○ None
- ○ Glucosamine/Chondroitin
- ○ Fish Oil
- ○ Borage Seed Oil
- ○ Thundergod Root
- ○ Feverfew
- ○ Capsaicin
- ○ Evening Primrose Oil
- ○ Other: _____

Please tell us what medications you are CURRENTLY taking for conditions other than arthritis, including osteoporosis, heart disease, lung disease, intestinal disease, and others. ○ Yes ○ No

	MEDICATION	STRENGTH (mg. per pill)	FREQUENCY
D3.			
D4.			
D5.			
D6.			
D7.			
D8.			
D9.			
D10.			
D11.			
D12.			
D13.			
D14.			
D15.			

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MEDICATION	STRENGTH (mg. per pill)	FREQUENCY
D16.		
D17.		

D18. What medicines are you allergic to? *(Allergy = itching, swelling, hives)*

- ◯ I am not allergic to any medicines
- ◯ I do not know if I am allergic to any medicines
- ◯ I am allergic to: _____

E. YOUR GENERAL HEALTH

E1. In the PAST 6 MONTHS, how many visits did you make to any of the following:

E1-1. Physical therapist	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-2. Massage therapist	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-3. Herbalist	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-4. Chiropractor	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-5. Acupuncturist	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-6. Exercise Physiologist/ Personal trainer	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more
E1-7. Homeopathic practitioner	◯ 0	◯ 1–4	◯ 5–8	◯ 9–12	◯ 13–16	◯ 17–20	◯ 21 or more

E2. During the PAST WEEK (even if it was not a typical week), how many minutes for the entire week did you spend:

	0	1–14	15–30	31–60	More than 60
E2-1. Stretching or strengthening exercise, including yoga	◯	◯	◯	◯	◯
E2-2. Weight training/resistance exercise	◯	◯	◯	◯	◯
E2-3. Swimming or aquatic exercise	◯	◯	◯	◯	
E2-4. Bicycling (including stationary/exercise bikes)	◯	◯	◯	◯	
E2-5. Walking for exercise	◯	◯	◯	◯	
E2-6. Aerobic exercise equipment (Stairmaster, etc.)	◯	◯	◯	◯	◯
E2-7. Other aerobic exercise, please specify:	◯	◯	◯	◯	◯

_____

E3. Are you ever troubled by breathlessness, other than in strenuous exertion?

◯ YES ◯ NO (If NO, please proceed to question #E4)

E3-1. Are you ever short of breath when hurrying on level ground or walking up a slight hill?

◯ YES ◯ NO (If NO, please proceed to question #E4)

E3-2. Do you have to walk slower than most people on level ground? Do you have to stop after a mile or so (or after 15 minutes) when you walk on level ground at your own pace?

◯ YES ◯ NO (If NO, please proceed to question #E4)

E3-3. Do you have to stop for breath after walking about 100 yards (or after a few minutes) on level ground?

◯ YES ◯ NO (If NO, please proceed to question #E4)

E3-4. Are you too breathless to leave the house or breathless after talking?

◯ YES ◯ NO (If NO, please proceed to question #E4)

E4. We are interested in learning more about your general health. Have you experienced or been diagnosed with any of the following conditions in the PAST 6 MONTHS?

Condition	Yes/No	Currently Active?
E4-1. High Cholesterol	Y N	Y N U
E4-2. High Blood Pressure	Y N	Y N U
E4-3. Heart Attack	Y N	Y N U
E4-4. Heart Failure	Y N	Y N U
E4-5. Angina/Chest Pain	Y N	Y N U
E4-6. Low Red Blood Cell Count (anemia)	Y N	Y N U
E4-7. Bronchitis	Y N	Y N U
E4-8. Pneumonia	Y N	Y N U
E4-9. Emphysema	Y N	Y N U
E4-10. Flu or influenza	Y N	Y N U
E4-11. Mononucleosis	Y N	Y N U
E4-12. Hayfever/Seasonal allergies	Y N	Y N U
E4-13. Asthma	Y N	Y N U
E4-14. Eczema	Y N	Y N U
E4-15. Stroke	Y N	Y N U
E4-16. TIA	Y N	Y N U
E4-17. Hyperthyroid	Y N	Y N U
E4-18. Hypothyroid	Y N	Y N U
E4-19. Type I Diabetes (Juvenile Onset)	Y N	Y N U
E4-20. Type II Diabetes (Adult Onset)	Y N	Y N U
E4-21. Lymphoma	Y N	Y N U
E4-22. Leukemia	Y N	Y N U
E4-23. Melanoma	Y N	Y N U
E4-24. Basal Cell Skin Cancer	Y N	Y N U
E4-25. Squamous Cell Skin Cancer	Y N	Y N U
E4-26. Breast Cancer	Y N	Y N U
E4-27. Lung Cancer	Y N	Y N U
E4-28. Prostate Cancer	Y N	Y N U
E4-29. Colon Cancer	Y N	Y N U
E4-30. Renal Cancer	Y N	Y N U
E4-31. Esophageal Cancer	Y N	Y N U

Condition	Yes/No	Currently Active?
E4-32. Thyroid Cancer	Y N	Y N U
E4-33. Brain Cancer	Y N	Y N U
E4-34. Other cancer:	Y N	Y N U
E4-35. Dry eyes/ mouth	Y N	Y N U
E4-36. Cataracts	Y N	Y N U
E4-37. Stomach Ulcer	Y N	Y N U
E4-38. Stomach Bleed	Y N	Y N U
E4-39. Irritable Bowel Syndrome	Y N	Y N U
E4-40. Reflux (Heartburn)	Y N	Y N U
E4-41. Prostate Problem	Y N	Y N U
E4-42. Osteoarthritis	Y N	Y N U
E4-43. Neck/Back problem	Y N	Y N U
E4-44. Osteoporosis	Y N	Y N U
E4-45. Broken bones since age 40	Y N	Y N U
E4-46. Early menopause (before age 40)	Y N	Y N U
E4-47. Ovaries removed before age 40	Y N	Y N U
E4-48. Parkinson's Disease	Y N	Y N U
E4-49. Multiple Sclerosis	Y N	Y N U
E4-50. Freq. Headaches	Y N	Y N U
E4-51. Migraines	Y N	Y N U
E4-52. Dementia	Y N	Y N U
E4-53. Depression	Y N	
E4-54. Alcoholism		
E4-55. Liver Disease		
E4-56. Hepatitis	Y N	
E4-57. Pancreatitis		
E4-58. Kidney Disease	Y N	U
E4-59. HIV/AIDS	Y N	
E4-60. Other:	Y N	
E4-61. Other:		
E4-62. Other:		

E5. If you broke a bone in the PAST 6 MONTHS, which bone did you break? *(Mark all that apply)*

○ Hip ○ Wrist ○ Spine ○ Arm ○ Other: _____

E6. Have you experienced an infection requiring antibiotics in the PAST 6 MONTHS.

○ YES ○ NO (If NO, please proceed to section F)

→ **E6-1. IF YES, which infections have you experienced in the PAST 6 MONTHS? Did you treat your infection with oral or IV antibiotics?**

	Oral	IV
○ Sepsis (blood stream infection)	○	
○ Pneumonia	○	
○ Upper Respiratory infection/cold	○	
○ Tuberculosis	○	
○ Bone/joint infection (osteomyelitis, septic joint, infected artificial joint)	○	
○ Skin infections (infected skin ulcer, cellulitis, infected nodules)	○	○
○ Urinary tract infection/kidney infection/bladder infection	○	○
○ Other infections requiring antibiotics –	○	○

Please specify: _____

Continue on next page →

F YOUR GENERAL HEALTH II

F1. During the PAST 6 MONTHS, have you had a flare in your rheumatoid arthritis?

◯ YES ◯ NO (If NO, please proceed to question #F2)

F1-1. If YES, how many flares have you had during the PAST 6 MONTHS?

◯ 1 ◯ 2–3 ◯ 4–5 ◯ More than 5

How did you treat your most recent flare? *(Mark all that apply)*

◯ New Medication—Please specify medicine: _____

◯ Increased strength of medication—Please specify medicine: _____

◯ Other Treatment—Please specify treatment: _____

◯ No treatment

F1-3. How long did your most recent flare last?

◯ Less than 1 day ◯ 1–3 days ◯ 4–6 days ◯ 1–2 weeks ◯ More than 2 weeks

F1-4. Has your most recent flare ended?

◯ YES ◯ NO

F2. Please indicate your average use, DURING THE PAST YEAR, of each specified beverage.

Mark only ONE response per item:

	Never	1 per day	2–3 per day	4–5 per day	6+ per day	1 per week	2–4 per week	5–6 per week	1–3 per month
F2-1. Regular Beer (1 glass, bottle, can)	◯	◯	◯	◯	◯	◯	◯	◯	◯
F2-2. Light Beer, e.g., Bud Light (1 glass, bottle, can)	◯	◯	◯	◯	◯	◯	◯		
F2-3. Red Wine (4 oz glass)	◯	◯	◯	◯	◯	◯			
F2-4. White Wine (4 oz glass)									
F2-5. Liquor, e.g., whiskey, gin (one drink or shot)		◯							

G. RECENT HEALTH CARE RESOURCE USE

G1. How many times have you visited a doctor (any kind of doctor, including a rheumatologist) in the PAST 6 MONTHS (do not include injections, medication by vein or infusions)?

◯ 0 visits ◯ 1–3 visits ◯ 4–6 visits ◯ 7 or more

G2. How many times have you visited a rheumatologist in the PAST 6 MONTHS (including your visit today)?

◯ 0 visits ◯ 1–3 visits ◯ 4–6 visits ◯ 7 or more

G3. Have you been to an emergency room/urgent care center during the PAST 6 MONTHS?

◯ YES ◯ NO (If NO, please proceed to question #G4)

G3-1. IF YES, how many times did you go to the emergency room/urgent care center?

time(s) [ ][ ]

Which hospital emergency rooms/urgent care centers did you go to?

Visit #1 _____ Visit #2 _____

G3-3. Date of visits: **Visit #1** ___/___/___ (mm dd year) **Visit #2** ___/___/___ (mm dd year)

	Visit #1	Visit #2
m	0 1	0 1
m	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9
d	0 1 2 3	0 1 2 3
d	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9
y	0	0
y	0 1 2 3 4 5 6 7 8	0 1 2 3 4 5 6 7 8

G3-4. Why did you go to the emergency room/urgent care center? What were your symptoms or your diagnosis?

_____

G4. Have you been hospitalized in the PAST 6 MONTHS?

○ YES ○ NO (If NO, please proceed to question #G5)

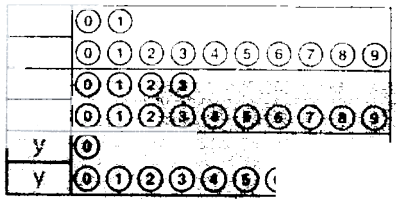
Hospitalization #1

G4-1. Which hospital did you go to?

_____

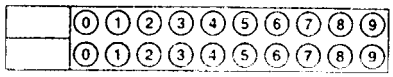
G4-2. When were you admitted to the hospital?

mm / dd / year



G4-3. How many days did you spend in the hospital?

_____ day(s)



G4-4. Why did you go to the hospital?

_____

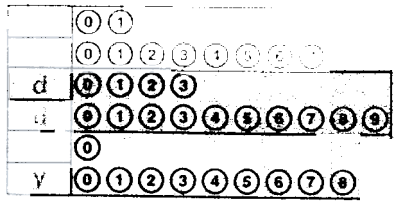
Hospitalization #2

G4-5. Which hospital did you go to?

_____

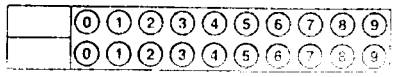
G4-6. When were you admitted to the hospital?

mm / dd / year



G4-7. How many days did you spend in the hospital?

_____ day(s)



G4-8. Why did you go to the hospital?

_____

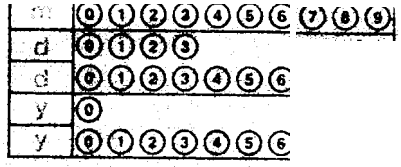
G5. Have you been in a nursing home or rehabilitation hospital during the PAST 6 MONTHS?

○ YES ○ NO (If NO, please proceed to question #G6)

G5-1. IF YES, which nursing home or rehabilitation hospital did you go to? _____

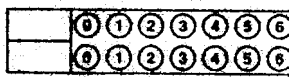
G5-2. When were you admitted to the nursing home or rehabilitation hospital?

mm / dd / year



G5-3. How many days did you stay in the nursing home or rehabilitation hospital?

day(s)



G5-4. Why did you go to the nursing home or rehabilitation hospital?

_____

G6. Have you had surgery in the PAST 6 MONTHS?

○ YES ○ NO (If NO, please proceed to question #G7)

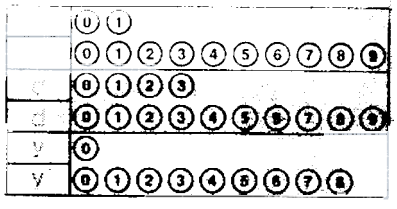
Surgery #1

G6-1. Where was your surgery performed?

_____

G6-2. When was your surgery performed?

mm / dd / year



G6-3. What kind of surgery did you have? (Include the part of body operated on)

_____

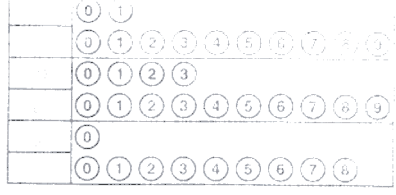
Surgery #2

G6-4. Where was your surgery performed?

_____

G6-5. When was your surgery performed?

mm / dd / year



G6-6. What kind of surgery did you have? (Include the part of body operated on)

_____

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G7. Has a home health care provider (such as a visiting nurse, therapist or homemaker) visited you in your home in the PAST 6 MONTHS?

◯ YES ◯ NO (If NO, please proceed to question #G8)

→ **G7-1. IF YES, how many times did the home health care provider visit you?** _____ time(s)

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0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

G8. Which of the following medical equipment have you used during the PAST 6 MONTHS?

◯ None ◯ Tub chair for showering ◯ Commode for bathroom ◯ Other: _____

◯ Wheel chair ◯ Walker ◯ Cane

G9. How many of the following diagnostic tests did you have in the PAST 6 MONTHS?

	0	1	2	3	4 or more
G9-1. Xray	◯	◯	◯	◯	◯
G9-2. MRI	◯	◯	◯	◯	◯
G9-3. CT scan	◯	◯	◯	◯	◯
G9-4. Endoscopy, gastroscopy (looking into stomach through a tube down the throat)	◯	◯	◯	◯	◯
G9-5. Colonoscopy or sigmoidoscopy	◯	◯	◯	◯	◯
G9-6. Bone density scan for osteoporosis	◯	◯	◯	◯	◯
G9-7. Cardiac catheterization/coronary angiogram	◯	◯	◯	◯	◯
G9-8. Cardiac angioplasty	◯	◯	◯	◯	◯
G9-9. Stress test	◯	◯	◯	◯	◯
G9-10. Carotid ultrasound	◯	◯	◯	◯	◯
G9-11. Sleep test	◯	◯	◯	◯	◯
G9-12. Lung tests/Breathing tests	◯	◯	◯	◯	◯

H. PREGNANCY HISTORY

H1. Have you ever experienced problems with infertility?

◯ YES ◯ NO (If NO, please proceed to question #H2)

→ **H1-1. Did your experience with infertility occur before or after your RA symptoms began?**

◯ Before the onset of RA symptoms

◯ After my onset of RA symptoms

◯ Both before and after the onset of RA symptoms

H2. Have you ever had a miscarriage?

◯ YES ◯ NO (If NO, please proceed to question #H3)

→ **H2-1. How many miscarriages have you had?** 0 1 2 3 4 5 6 7

H2-2. How many miscarriages did you have:

	Before 12 weeks (1st trimester)	After 12 weeks (2nd-3rd trimester)
Before your RA symptoms began	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
After your RA symptoms began	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

H3. Have you ever been pregnant?

◯ YES ◯ NO

Pregnancy #1

→ **H3-1. Was this pregnancy before or after your RA symptoms began?**

◯ Before ◯ After

H3-2. What was the outcome of the pregnancy? *(Mark all that apply)*

◯ Liveborn

◯ Termination

◯ Stillbirth

◯ Twins

◯ Minor or major birth defects: _____

H3-3. What was the baby's birth weight?

◯ Less than 5 pounds ◯ 7.1 to 8.5 pounds

◯ 5 to 5.5 pounds ◯ 8.6 to 10 pounds

◯ 5.6 to 7 pounds ◯ More than 10 pounds

H3-4. What was the baby's gender?

◯ Female ◯ Male

H3-5. Number of weeks at delivery?

◯ 32 weeks or less (pre-term)

◯ 33-37 weeks

◯ More than 37 weeks (full term)

Continue on next page

Pregnancy #2

H4-1. Was this pregnancy before or after your RA symptoms began?

◯ Before ◯ After

H4-2. What was the outcome of the pregnancy?
(Mark all that apply)

◯ Liveborn
◯ Termination
◯ Stillbirth
◯ Twins
◯ Minor or major birth defects:

H4-3. What was the baby's birth weight?

◯ Less than 5 pounds ◯ 7.1 to 8.5 pounds
◯ 5 to 5.5 pounds ◯ 8.6 to 10 pounds
◯ 5.6 to 7 pounds ◯ More than 10 pounds

H4-4. What was the baby's gender?

◯ Female ◯ Male

H4-5. Number of weeks at delivery?

◯ 32 weeks or less (pre-term)
◯ 33-37 weeks
◯ More than 37 weeks (full term)

Pregnancy #3

H5-1. Was this pregnancy before or after your RA symptoms began?

◯ Before ◯ After

H5-2. What was the outcome of the pregnancy?
(Mark all that apply)

◯ Liveborn
◯ Termination
◯ Stillbirth
◯ Twins
◯ Minor or major birth defects:

H5-3. What was the baby's birth weight?

◯ Less than 5 pounds ◯ 7.1 to 8.5 pounds
◯ 5 to 5.5 pounds ◯ 8.6 to 10 pounds
◯ 5.6 to 7 pounds ◯ More than 10 pounds

H5-4. What was the baby's gender?

◯ Female ◯ Male

H5-5. Number of weeks at delivery?

◯ 32 weeks or less (pre-term)
◯ 33-37 weeks
◯ More than 37 weeks (full term)

Pregnancy #4

H6-1. Was this pregnancy before or after your RA symptoms began?

◯ Before ◯ After

H6-2. What was the outcome of the pregnancy?
(Mark all that apply)

◯ Liveborn
◯ Termination
◯ Stillbirth
◯ Twins
◯ Minor or major birth defects:

H6-3. What was the baby's birth weight?

◯ Less than 5 pounds ◯ 7.1 to 8.5 pounds
◯ 5 to 5.5 pounds ◯ 8.6 to 10 pounds
◯ 5.6 to 7 pounds ◯ More than 10 pounds

H6-4. What was the baby's gender?

◯ Female ◯ Male

H6-5. Number of weeks at delivery?

◯ 32 weeks or less (pre-term)
◯ 33-37 weeks
◯ More than 37 weeks (full term)

Pregnancy #5

H7-1. Was this pregnancy before or after your RA symptoms began?

◯ Before ◯ After

H7-2. What was the outcome of the pregnancy?
(Mark all that apply)

◯ Liveborn
◯ Termination
◯ Stillbirth
◯ Twins
◯ Minor or major birth defects:

H7-3. What was the baby's birth weight?

◯ Less than 5 pounds ◯ 7.1 to 8.5 pounds
◯ 5 to 5.5 pounds ◯ 8.6 to 10 pounds
◯ 5.6 to 7 pounds ◯ More than 10 pounds

H7-4. What was the baby's gender?

◯ Female ◯ Male

H7-5. Number of weeks at delivery?

◯ 32 weeks or less (pre-term)
◯ 33-37 weeks
◯ More than 37 weeks (full term)

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