Uniform databases in early arthritis:
Specific measures to complement classification criteria
and indices of clinical change

T. Pincus¹, T. Sokka¹²

¹Vanderbilt University Medical Center, Nashville, Tennessee, USA; ²Jyväskylä Central Hospital, Jyväskylä, Finland.

Please address correspondence to:
Theodore Pincus, MD, Professor of Medicine; Tuulikki Sokka, MD, PhD, Assistant Professor of Medicine.

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Key words: Database, patient questionnaire, joint count, Core Data Set, Disease Activity Score (DAS).

ABSTRACT

Rheumatoid arthritis (RA) is not characterized by a single pathognomonic measure such as blood pressure in hypertension or cholesterol in hyperlipidemia, which can be used in the diagnosis, prognosis, and monitoring of patient status. Measures such as swollen joints and an elevated erythrocyte sedimentation rate are certainly valuable, but many individuals with abnormal values have conditions other than RA, and many people with RA may have favorable values for one or more of these measures. Therefore, the rheumatology community has developed indices of several measures, such as classification criteria, the disease activity score (DAS), and the ACR Core Data Set with 20%, 50% and 70% improvement (ACR 20, ACR 50, ACR 70) to classify and monitor patients with RA.

While these indices have greatly advanced clinical research, databases for long-term observations, including those in early RA described in this Supplement, differ in 20-50% of included data, and the software platforms for these databases differ sufficiently to render it difficult to merge the data to compare one data set to another. It has been proposed that a uniform database for early arthritis clinical research could help advance clinical research in early arthritis. One example of such a database, termed a "standard protocol to evaluate rheumatoid arthritis" (SPERA), has been in use for almost two decades in one clinical site, and has proven valuable in a number of ways, including the demonstration of early radiographic damage, development of a 28-joint count, and documentation that patient questionnaire data are correlated significantly with laboratory, joint count and radiographic data, although questionnaire data are the strongest predictors of severe outcomes including work disability and premature mortality. The use of a uniform database in no way precludes the collection of additional data at particular centers including immunogenetic, serologic, or structural magnetic resonance imaging (MRI) data. However, the availability of an infrastructure of standard data in all RA databases would enhance clinical research in early RA.

Rheumatoid arthritis (RA) differs from other dysregulatory chronic diseases such as hypertension or hyperlipidemia, in that a robust, single, quantitative pathognomonic measure, such as an elevated blood pressure or elevated cholesterol, is not available for diagnosis, prognosis and management in RA. Measures such as swollen joints, functional disability, rheumatoid factor and an elevated erythrocyte sedimentation rate (ESR) are certainly valuable in diagnosis and prognosis. However, many individuals identified by these markers have conditions other than RA, and many people with progressive RA may have relatively favorable values for one or more of these measures. Hence, the management of RA is generally not conducted according to any single measure, as is management of hypertension and hyperlipidemia, and often is not conducted according to any quantitative measure.

The rheumatology community has addressed the absence of a single pathognomonic measure by identifying clusters of different types of quantitative measures such as criteria for classification of patients (1, 2), clinical status such as the disease activity score (DAS) (3, 4) and the American College of Rheumatology (ACR) Core Data Set.
(5-7), and improvement (8). Classification criteria for RA (1, 2) have provided a major advance, allowing the identification of relatively homogeneous cohorts of patients in clinical trials and other clinical research. However, they are quite limited for prognosis and function poorly in early RA (9, 10). Specific measures, such as the number of involved joints or poor functional status, have substantially greater prognostic value than classification criteria for predicting short-term persistence and long-term severity (10).

The DAS (3, 4) and ACR Core Data Set (5-7) have been invaluable reporting standards in clinical trials. However, these indices include only measures of disease activity, such as swollen joint counts and ESR, and do not include measures of damage such as deformed joints, or outcomes such as joint replacement surgery (11). One measure of damage, a radiographic score, is included in the ACR Core Data Set for studies of longer than one year or longer, but is not included in ACR 20, 50 or 70 improvement criteria (8). Changes in clinical status in RA are reported generally in the rheumatology literature as DAS and ACR 20 indices, rather than as individual measures, and outcomes other than radiographic scores are not analyzed according to a single baseline measure, such as blood pressure or cholesterol.

Several reports have presented documentation of specific markers in predicting work disability (12-14) and mortality in RA (15-18), including a high number of involved joints, poor functional status documented by a patient questionnaire, physical measures such as grip strength, walk time, and the button test, as well as comorbid cardiovascular disease. These analyses have provided some initially surprising results, such as the higher prognostic value of patient questionnaires than joint counts, radiographic scores, rheumatoid factor or ESR for long-term outcomes (19), and the observation that relatively simple measures such as patient questionnaires of 20 or 8 activities of daily living and joint counts of 28, 12, and even 6 joints provide powerful prognostic indicators (15). In larger data sets, radiographic scores and laboratory tests also serve to predict mortality (17). However, in no data set are these variables as powerful as self-report questionnaire scores for functional disability in predicting outcomes such as work disability or mortality, in part because only a minority of patients has the poorest clinical status according to radiographic and laboratory data (17).

Clinical trials, clinical research and clinical care of RA all require a baseline database of measures pertinent to the prognosis, care, and outcomes of individual patients. Most such databases are 50-80% identical, as there is general consensus concerning the appropriate measures. However, some differences are seen in the data collected, as well as in the platforms and software used for the organization and storage of these data. These differences limit severely the capacity to compare information and outcomes from different sources, similar to the limitations in interpretation of clinical trial data prior to introduction of the DAS and ACR 20.

A consensus recommendation for a "core set of domains in reporting requirements for longitudinal observational studies in rheumatology" emerged from an Outcome Measures in Rheumatoid Arthritis Clinical Trials (OMERACT) conference in 1998 (20). This report suggested 5 core domains: health status, disease process, damage, mortality, and toxicity/adverse reactions. Two additional domains, work disability and costs, were recognized as important, but did not need to be included in all longitudinal studies. This effort may be viewed as an effort to extend the concept of a uniform clinical database for rheumatic diseases, initially proposed by Fries in the 1970s (21, 22), beyond clinical trials to routine clinical care. Such a uniform database presents an effort toward standardization, just as a laboratory test such as the erythrocyte sedimentation rate evolved from different methods to a single Westergren method, which provides a measure that all rheumatologists can interpret similarly.

A uniform database in no way excludes specialized studies of specific interest, such as magnetic resonance imaging (MRI) scans, serologic markers, immunogenetic markers or others. Indeed, a core set of uniform measures would provide a baseline that could be used by all rheumatologists and provide a strong platform for "evidence-based" rheumatology.

There is no single "best" database for the long-term observation of RA, and many excellent approaches exist to collect data on patients with early arthritis or established RA, as seen in the many protocols in reports in this Supplement. We summarize here a uniform database which has been used in our research for more than 18 years, which we have termed a "standard protocol to evaluate rheumatoid arthritis" (SPERA) (23).

This protocol provides a pragmatic assessment in 5 pages that can be completed in 15-30 minutes, to capture most information collected on an initial visit of a patient with early arthritis who might have RA.

The SPERA protocol has evolved somewhat over the 18 years, but the database is 95% identical over almost 2 decades, and has proven useful in clinical research concerning the prognosis and monitoring of patients, including observation of radiographic damage in most patients within the first 2 years of disease (24), development of a 28-joint count (25), recognition that patient questionnaires are correlated significantly with joint counts, radiographic scores and laboratory tests (26), although they are better predictors of work disability (27) and mortality (14, 18), and of the relatively small proportion of patients who were eligible for clinical trials in the contemporary care of RA (28, 29).

The 5 pages of the SPERA protocol are designed to assess:

1. Clinical features - Classification criteria, comorbidities, extra-articular manifestations, surgeries, laboratory tests, family history, and work status (Appendix I).
2. Medications used for RA (Appendix II).
3. A 42-joint count, which includes 10 proximal interphalangeal (PIP) joints of the hand, 10 metacar-
pophalangeal (MCP) joints of the hand, 2 wrists, 2 elbows, 2 shoulders, 2 hips, 2 knees, 2 ankles and 10 metatarsophalangeal (MTP) joints (hips and shoulders are not scored for swelling). All joints are scored for tenderness, swelling (except hips and shoulders), limited motion, and surgery, with a space to indicate that a joint is normal (Appendix III).

4. A patient self-report Multi-Dimensional Health Assessment Questionnaire (MDHAQ) including the modified Health Assessment Questionnaire (MHAQ) for functional capacity, visual analog scales to assess pain, global health and fatigue, minutes of morning stiffness, and a symptom checklist (Appendix IV).

5. Radiographic scoring sheet according to the Sharp or Larsen scores. A standard HAQ or clinical HAQ (CLINHAQ) may be used. Microsoft access software is available to record and store these data if a computer record is desired. However, computerization is needed only if analyses of groups of patients is desired. The 2 pages of clinical features and medications are kept on in the patient record, without computer recording, for updating in standard care.

A brief summary of data concerning patients with early RA, termed the "early rheumatoid arthritis treatment evaluation registry" (ERATER) (28-30), evaluated according to the SPERA method is summarized briefly here. These data concerning 426 patients, 332 of whom were seen at a private practice rheumatology setting in Nashville, Tennessee by five private practice rheumatologists, and 94 of whom were seen at different sites, including 31 at Vanderbilt University by TP, are presented to illustrate the potential use of such a database.

Demographic features (Table I) indicate a mean age of 52.9 years, and a mean education of 13.1 years; the practice rheumatologists, and 94 of whom were seen at different sites, including 31 at Vanderbilt University by TP, are presented to illustrate the potential use of such a database.

Demographic features (Table I) indicate a mean age of 52.9 years, and a mean education of 13.1 years; the cohort is 73.7% female, 65% married, and 86.6% Caucasian, rather typical features of patients with RA. Because this was a database in which patients had up to 3 years of disease, most met classification criteria for RA (Table II), including 86.6% with morning stiffness greater than 1 hour, 90.8% with soft tissue swelling of 3 or more groups, 95% with swelling of PIP, MCP or wrist joints, 89.7% with symmetrical swelling, and 66.2% with positive rheumatoid factor. However, only 38.7% had radiographic erosions (suggesting improved status at this time) and only 9.4% had subcutaneous nodules. Most extra-articular features in this group with relatively early RA were seen in fewer than 2% of patients (Table III), other than subcutaneous nodules in 9.4% and carpal tunnel syndrome in 18.3% of patients. Analyses of comorbidities (Table IV) indicates hypertension in 31.5%, ischemic heart disease in 5.2%, peptic ulcer in 6.3%, cancer in 8.9% and cataracts in 10.1% of patients, again within the first 3 years of RA. The high level of cataracts within the first 3 years of RA is somewhat surprising. Overall, 53.5% had ever smoked, 27% were current smokers, 7.5% had undergone carpal tunnel surgery, 7.3% back surgery, and 6.6% cataract surgery (Table V). The family history indicated RA in the father in 8%, the mother in 10.6%, siblings in 7.3%, and children in 1.2% (Table VI).

The most prominently involved joint for tenderness was the wrist (Table VII), and for swelling the second and third MCP, the third PIP, and the wrists. Limited motion or deformity, which are included in the SPERA as baseline measures of damage, was most common in wrists. No specific joint was affected by tenderness or swelling in more than 51% of patients (Table VIII).

Among therapies, methotrexate was the first therapy used in 81% of patients compared to 7.7% hydroxychloroquine, and 3.8% leflunomide (Table VIII),
reflecting the practice in Nashville, Tennessee, where most of these patients were identified (30). These data illustrate the potential for a uniform database that could be available for the clinical assessment of patients with early RA. Again it is emphasized that this is not presented as a “perfect” database, but as a model of an information acquiring system that can be completed for most patients in 15-30 minutes. The SPERA assessment provides a database of most variables that are considered to be relevant to short-term responses to therapies as well as to long-term outcomes not only for clinical research, but also for standard long-term clinical care. The specific single measures can then be applied to studies in immunogenetics, serologic markers, imaging markers, and other clinical research to better stratify patients than classification criteria. If such a database were common to the infrastructure of all rheumatology care and research, it might provide specific markers, as is the case for single markers such as hypertension or hypercholesterolemia, to enhance long-term knowledge. Recognition of important specific measures such as poor functional status or a high number of involved joints as potential predictors of work disability and death, might enhance recognition of the urgency of treatment for RA, as is now the case for cardiovascular diseases.

**References**

1. ROPES MW, BENNETT GA, COBB S, JACOX RF, JESSAR RA: 1958 revision of diagnostic criteria for rheumatoid arthritis. *Bull Rheum*
On the following pages, forms that have been in use for almost 20 years to collect patient information for the SPERA database are reproduced. Rheumatologists and clinical investigators are invited to use these forms in clinical care and clinical research.

APPENDIX

On the following pages, forms that have been in use for almost 20 years to collect patient information for the SPERA database are reproduced. Rheumatologists and clinical investigators are invited to use these forms in clinical care and clinical research.


III. Joint examination form.

IV. Multi-Dimensional Health Assessment Questionnaire (F582-NP2).
Clinical Lifetime Updateable Evaluation (CLUE - RA) - Rheumatoid Arthritis Clinical Features (R606)

This form is designed to be updated at subsequent patient visits to provide a lifetime record.

NAME: Last _______ First _______  DOB ______________________  ID# ______________________  DATE ______________________

CLUE FORM COMPLETED BY ________________________  RA-Dx (Mo/Yr) _______  RA-1st Symptom _______  Race _______ Insurance _______

1st Visit (Mo/Yr) _______  1st Rheumatologist _______  1st DMARD used _______  1st DMARD (Mo/Yr) _______

ARA CRITERIA FOR RA (Please enter "—" or "+")

("—" may be updated to "+"); Ever? If "+", but a blank space is unknown) "—" or "+" Mo/Yr

Morning Stiffness > 1 hour _______  Soft tissue swelling of = 3 ft groups _______

Swelling of PIP, MCP, or wrist joints _______  Symmetrical Swelling _______

Subcutaneous Nodule _______  Positive Rheumatoid Factor _______

Radiographic Erosion _______  Highest Rheumatoid _______

FAMILY HISTORY OF RA (Please enter "—" or "+"):

Parent _______ Father _______ Mother _______

Sibling # _______ Brother(s) # _______ Sisters(s) # _______

Child # _______ Son(s) # _______ Daughters(s) # _______

Other Family _______

EXTRA-ARTICULAR DISEASE (enter "—" or "+") If "+", Ever? Onset "—" or "+" Mo/Yr

Severe Osteoporosis _______  Severe Osteoarthritis _______

Severe Infection _______  Herpes Zoster/Shingles _______

Musculoskeletal trauma _______  Fractures since age 50 _______

Chronic Back Pain _______  Chronic renal failure _______

Alcoholism _______  Smoking: Ever _______ #Pk _______ Start Yr _______

Smoking: Now _______ PkYrs _______ Yr D/C _______

RADIOGRAPH DATES: (H-Hands, F-Feet, B-Both)

BONE DENSITOMETRY DATES: (Mo/Day/Yr)

SURGERIES Ever? If "+", "—" or "+" Mo/Yr Mo/Yr Mo/Yr

Carpal Tunnel _______  Heart Bypass _______  Back Surgery _______

Cataract _______

JT SURGERY/FRACTURE (A-Arthroscopy, S-Synovectomy, TJR-Replacement, JF-Fusion, JR-Reconstruction, F-Fracture)

R/L Hand (mo/yr) _______  R/L Elbow (mo/yr) _______

R/L Hip (mo/yr) _______  R/L Foot (mo/yr) _______

R/L Knee (mo/yr) _______  C-Spine (mo/yr) _______

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Clinical Lifetime Updateable Evaluation (CLUE - MED) - Rheumatoid Arthritis Medications (R607)

This form is designed to be updated at each patient visit to provide a lifetime record. Date of Last Update: 
PT NAME:  
DOB:  
(Use pencil)

(If a DMARD has been discontinued more than three months, the 2nd course begins in blank space or cross out another drug and begin 2nd course there.)

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INFliximab  
Dose: | Date: |

Efficacy Code: NO=No benefit, SOME=Some benefit, MUCH=Much benefit, REM=Remission, WO=Worse, UNK=Unknown  
Toxicity Code: NO=No toxicity, NA=Nausea, DI=Diarrhea, GI=Other GI, HA=Hair loss, RA=Rash, MU=Mucous, LIVER=Liver enzymes, HEM=Hematology, PROT=Proteinuria, CREAT=Creatinine, BP=Hypertension, RESP=Respiratory, NODUL=Nodules, INF=Infections, OTH=Other  
Reason for discontinuation: TOX=Toxicity, specify (Toxicity Code above), INEFF=Inefficacy, LOSS=Loss of efficacy, COST=Costs, COMORB=Comorbidities, PREG=Pregnancy, PAT=Patient's decision, MD=MD stopped, REM=Remission/Not needed, DEAD=Patient died, OTH=Other

NSAID review. (Taken continuously over at least 2 weeks for arthritis.)

| -- may be updated in future to + | Ever | Start date (mo/yr) | Stop date (mo/yr) | Efficacy (Code or description) | Toxicity (Code or description) | Reason to stop | If toxicity code/description |
| ACETAMINOPHEN (TYLENOL) | | | | | | |
| ASPRIN | | | | | | |
| IBUPROFEN (ADVIL, NUPRIN) | | | | | | |
| MAFROXEN (ALEVE) | | | | | | |
| DICLOFENAC (VOLTAREN) | | | | | | |
| NABUMATONE (RELAFEN) | | | | | | |
| CELECOXIB (CELEBREX) | | | | | | |
| ROFECOXIB (VIOXX) | | | | | | |
| MELOXICAM (MODIC) | | | | | | |
| VALDECOXIB (Bextra) | | | | | | |

Additional drugs and/or other courses may be entered in blank spaces.

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JOINT EXAMINATION FORM

PT Name ____________________ Date__________________ R608-JT

Please mark below your assessment of the patient’s current disease activity:

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<th>NO</th>
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JOINT COUNT - SCORE EACH JOINT AS: "+" or "POSitive" or "ABNormal" versus "+-" or "NEGative" or "NORMAL"

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<td>L-MTP3</td>
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<td>L-MTP5</td>
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</table>

§ = Synovectomy  J = Total Joint Replacement (TJR)  O = Other

Description only - not in formal joint count:

NECK ____________________ FEET ____________________
BACK ____________________ OTHER ____________________

Indicate positive tender points:
Multi-Dimensional Health Assessment Questionnaire (R605-NP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1. Please check (✓) the ONE best answer for your abilities at this time:
   OVER THE LAST WEEK, were you able to:
   
<table>
<thead>
<tr>
<th>Without ANY Difficulty</th>
<th>With SOME Difficulty</th>
<th>With MUCH Difficulty</th>
<th>UNABLE To Do</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>a. Dress yourself, including tying shoelaces and doing buttons?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
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<tr>
<td>b. Get in and out of bed?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
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<td>c. Lift a full cup or glass to your mouth?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
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<tr>
<td>d. Walk outdoors on flat ground?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>e. Wash and dry your entire body?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>f. Bend down to pick up clothing from the floor?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>g. Turn regular faucets on and off?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
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<tr>
<td>h. Get in and out of a car, bus, train, or airplane?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
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<tr>
<td>i. Walk two miles?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>j. Participate in sports and games as you would like?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>k. Get a good night's sleep?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>l. Deal with feelings of anxiety or being nervous?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
<tr>
<td>m. Deal with feelings of depression or feeling blue?</td>
<td>__0</td>
<td>__1</td>
<td>__2</td>
</tr>
</tbody>
</table>

2. How much pain have you had because of your condition OVER THE PAST WEEK?
   Place a mark below to indicate how severe your pain has been:
   
   NO PAIN | | PAIN AS BAD AS IT COULD BE

3. How would you rate your general health?
   
   Excellent_(1), Very good_(2), Good_(3), Fair_(4), Poor_(5)

4. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?
   Place a mark below to indicate how severe your fatigue has been:
   
   FATIGUE IS | FATIGUE IS A MAJOR PROBLEM
   NO PROBLEM | |

5. How do you feel TODAY compared to ONE WEEK AGO? Please check (✓) only one.
   
   Much Better_(1), Better_(2), the Same_(3), Worse_(4), Much Worse_(5) than one week ago

6. Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing:
   
   VERY WELL | | VERY POORLY

7. What is the reason that you are seeing a doctor today? Please check and write anything you would like.
   □ Check-up, □ A new illness or problem, □ Managing an illness, □ Other, Please write below any further information which you think will help in your care - you don't need to write anything - and turn to the other side:
8. Please check (√) if you have experienced any of the following over the last month:

- Fever
- Weight gain (>10 lbs)
- Weight loss (<10 lbs)
- Feeling sickly
- Headaches
- Unusual fatigue
- Swollen glands
- Loss of appetite
- Skin rash or hives
- Unusual bruising or bleeding
- Tiredness
- Other skin problems
- Loss of hair
- Dry eyes
- Other eye problems
- Problems with hearing
- Ringing in the ears
- Stuffy nose
- Sore throat
- Sore mouth
- Dry mouth
- Problems with smell or taste
- Lump in your throat
- Cough
- Shortness of breath
- Wheezing
- Pain in the chest
- Heart pounding (palpitations)
- Trouble swallowing
- Heartburn or stomach gas
- Stomach pain or cramps
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Dark or bloody stools
- Problems with urination
- Gynecological (female) problems
- Dizziness
- Losing your balance
- Muscle pain, aches, or cramps
- Muscle weakness
- Paralysis of arms or legs
- Numbness or tingling of arms or legs
- Fainting spells
- Swelling of hands
- Swelling of ankles
- Swelling in other joints
- Joint pain
- Back pain
- Neck pain
- Use of drugs not sold in stores
- Smoking cigarettes
- More than 2 alcoholic drinks per day
- Depression - feeling blue
- Anxiety - feeling nervous
- Problems with thinking
- Problems with sleeping
- Sexual problems
- Burning in sex organs
- Problems with social activities

Please check (√) here if you have had none of these symptoms: ________.

9. What is your current occupation? (If you are not working now, what was your past occupation?)

10. How many other people live at home with you? ___

- Spouse/partner
- Parents
- Sons or daughters
- I live alone
- Others (describe)

11. At this time, are you? [Please check (√) all that apply.]

- Working full time
- Retired
- Working part time
- Student
- Homemaker-full time
- Disabled
- Other (describe)

12. How many years of school have you completed? Please circle the number of years of school.

1 2 3 4 5 6 7 8 9 10

11 12 13 14 15 16 17 18 19 20

Your Name ____________________________

Street Address ____________________________

City ____________________________ State ______ Zip ______

Today's Date ____________________________

Time of Day ______ AM | PM ______

Telephone ______ Area Code ______
Number ______ Social Security # ______

Date of Birth ____________________________

SEX: □ Female □ Male

ETHNIC □ Asian □ Black □ Hispanic □ White □ Other

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Separated

Please check if this questionnaire is completed entirely by patient □ or with help from (name) □

13. Please write below ALL pills that you took over the last TWO WEEKS, with or without a prescription. Please include aspirin, birth control pills, pain pills, alternative therapy, health supplements and any pills sold in health food stores:

NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY ______

DOSE (if known) ______

How many per day or week ______

NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY ______

DOSE (if known) ______

How many per day or week ______

1. ______ ______ ______ ______

2. ______ ______ ______ ______

3. ______ ______ ______ ______

4. ______ ______ ______ ______

5. ______ ______ ______ ______

Please list the name and telephone number of your primary care physician:

Name ____________________________ Telephone ____________________________

Please list the name of your insurance carrier:

Insurance ____________________________ Identification number ____________________________

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE TO MONITOR YOUR MEDICAL SITUATION.

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