

The Cedars-Sinai Rheumatoid Arthritis Health-Related Quality Of Life Instrument

Please answer each question by thinking about how your rheumatoid arthritis has affected your life **during the past four weeks**. There are no right or wrong answers to the questions. Please answer every question with one mark (X) only.

Example:

The following is an example of how to answer each question. Do not answer this question.

**During the past 4 weeks,
how often ...**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
1. Did you have stiffness in your joints? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE BEGIN HERE....

**During the past 4 weeks, how
difficult was it for you to...**

	Not Difficult &	A Little Difficult &	Somewhat Difficult &	Very Difficult &	Extremely Difficult &
1. Get in or out of bed?M 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Get in or out of a chair?.....M 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climb stairs?M 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Walk one block?M 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do such things as dress yourself or shampoo your hair?.....D 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Use the telephone, computer or tie your shoes?.....D 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Grasp objects (such as a book or steering wheel)?.....D 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Use a knife and fork?.....D 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Zip a zipper or button buttons on your clothing?.....D 9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Open a jar or turn a doorknob?D 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how severe....**

	Not At All &	Very Mild &	Mild &	Moderate &	Severe &
11. Was your overall pain or discomfort? D 11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how often....**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
12. Did your joints “lock-up” or become stiff?..... M 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Did pain or discomfort cause you to change positions while sitting or lyingdown?..... M 13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Did you wakeup during the night because of pain or discomfort?..... M 14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Did fatigue limit your daily activities?..... PA 15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Did you notice a sharp decline in your energy level during the afternoon?..... PA 16	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you feel down when you thought about how you are less able to do the kinds of activities you once did? EWB 17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Were you worried that someday you would have to completely depend on others to help you with your rheumatoid arthritis?..... EWB 18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Was your rheumatoid arthritis on your mind?..... EWB 19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Were you worried that your rheumatoid arthritis could cause bone loss or deformities to your joints? EWB 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how often...**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
21. Were you worried that one day you would not be able to afford medication or professional care? EWB 21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Were you worried about the side effects caused by the medication(s) that you take for your rheumatoid arthritis?..... EWB 22	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Were you frustrated with having to take medication for your rheumatoid arthritis?..... EWB 23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Did you feel frustrated because you were not able to control or get relief from your rheumatoid arthritis? EWB 24	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Did physical limitations interfere with your ability to do paid work, household work or school work as carefully or efficiently as you would like?..... PA 25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how often...**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
26. Did physical limitations keep you from doing paid work, household work or schoolwork?..... PA 26	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Did physical limitations cause you to do less paid work, schoolwork or household work? PA 27	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Did emotional difficulties cause you to do less paid work, household work or school work?..... PA 28	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Did fatigue, pain or discomfort interfere with your enjoyment of sex? SF 29	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Did fatigue, pain or discomfort keep you from having sex? SF 30	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how often ...**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
31. Did you spend time with others?..... PA 31	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Did your health prevent or reduce your participation in social activities such as going to parties, dinner, or the movies? PA 32	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Did your health cause you to avoid or fear contact with others such as hugging or hand shaking?... D 33	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Figure 2

The 11-Item Rheumatoid Arthritis Health-Related Quality Of Life Instrument

Please answer each question by thinking about how your rheumatoid arthritis has affected your life **during the past four weeks**. There are no right or wrong answers to the questions. Please answer every question with one mark (X) only.

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PLEASE BEGIN HERE....

**During the past 4 weeks, how
difficult was it for you to...**

	Not Difficult &	A Little Difficult &	Somewhat Difficult &	Very Difficult &	Extremely Difficult &
1. Get in or out of a chair?M 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Climb stairs?M 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Zip a zipper or button buttons on your clothing?D 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Open a jar or turn a doorknob?D 11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how severe...**

	Not At All &	Very Mild &	Mild &	Moderate &	Severe &
5. Was your overall pain or discomfort?.....M 14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 4 weeks,
how often....**

	Never &	Almost Never &	Sometimes &	Very Often &	Always &
6. Did fatigue limit your daily activities?..... PA 15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you feel down when you thought about how you are less able to do the kinds of activities you once did? EWB 17	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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10. Did physical limitations interfere with your ability to do paid work, household work or school work as carefully or efficiently as you would like? PA 25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Did your health prevent or reduce your participation in social activities such as going to parties, dinner, or the movies?..... PA 32	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>