Ref.no (for office use)

LoRoS Questionnaire *(version 5)*

Spondyloarthropathies in multicultural populations in London.

Do you need an interpreter to fill in this questionnaire? Yes ☐ No ☐

1. *Demographics*

FULL NAME: _____ DATE (today): _____

ADDRESS _____ SEX: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____Place of birth _____

If born outside UK when (year) did you arrive in the UK_____

E-MAIL ADDRESS (if there is any): _____

NAME OF Rheumatologist: _____

Contact OF DOCTOR (e-mail address/ postal or telephone): _____

To which of the following groups do you consider that you belong?

ASIAN	BLACK	EUROPEAN	MIXED	OTHER
Bangladeshi	African		Describe	Describe
Chinese	Caribbean		_____	_____
Indian	Other_____	_____		
Pakistani				
Other-------				

What is the main language spoken in your household? _____

SMOKING

Never smoked	
Ex-smoker	
Smoker	
Between 1-5 cigarettes/day	
5-10	
10-20	
More than 20	

DO YOU DRINK ALCOHOL?

Never	
Socially	
Daily	

2. Clinical I (Disease onset)

a) When did your disease begin? (Year and age) _____

b) When was the diagnosis made? (Year and age) _____

c) What was your first complaint/symptom?

Buttock pain	
Back pain	
Neck pain	
Knee pain/swelling	
Shoulder pain	
Foot pain/swelling	
Hip pain	
Eye inflammation	
Headache	
Don't remember	
Other	

3. In your opinion, what is the <u>main</u> problems that the disease is causing to you? (*Please put a number in each box in order, 1 being worst, 2 being second worst, etc.*)

Tiredness (Fatigue)	
Neck pain	
Upper back pain	
Lower back pain	
Stiffness	
Joint pain / swelling	
Pain with pressure on various areas	
Other (what)	

Clinical II (associations)

4) Other than joints/back pain, do you have any other problems with any of the following: *(tick more than one if there many)*

Heart	
Lungs	
Dizziness	
Headaches	
Numbness	
Kidneys/ water works	
Other	
No other problems	

5. Have you ever had OR now have: ***(Tick more than one if there are many)***

Eye inflammation	
Psoriasis	
Dry skin in your hair or itchiness	
Dry skin elsewhere in body	
Irritable bowel	
Stomach irritation of any sort	

6. Osteoporosis:

a) Have you been told that you have "brittle" bones/osteoporosis? Yes ☐ No ☐
(*Tick the right one for you)*

b) Have you ever had the special scan (DEXA)to confirm this? Yes ☐ No ☐

Clinical III (BASDAI)

7. PLEASE PLACE a vertical mark (for example___/____) on each line below indicating your answer to each question (ranking your symptoms) relating to the PAST WEEK.

1) How would you describe the overall level of fatigue / tiredness you have experienced?

NONE _____VERY SEVERE

2) How would you describe the overall level of AS neck, back or hip pain you have had?

NONE _____ VERY SEVERE

3) How would you describe the overall level of pain/swelling in joints other than neck, back or hips you have had?

NONE _____VERY SEVERE

4) How would you describe the overall level of discomfort you have had from any areas tender to touch or pressure?

NONE _____ VERY SEVERE

5) How would you describe the overall level of morning stiffness you have had from the time you wake up?

NONE _____VERY SEVERE

6) How long does your morning stiffness last from the time you wake up in the past week?

0	1/2	1 hrs	1 1/2	2 or more hrs

a) How would you describe the overall level of night pain you have had in the past week?

NONE _____ VERY SEVERE

b) How would you describe the overall level of disturbance to your sleep due to your disease?

NONE _____VERY SEVERE

8. Function: Please place a mark on each line below to indicate your level of ability with EACH OF THE FOLLOWING ACTIVITIES during PAST WEEK: (*N.B. An aid is a piece of equipment which helps you to perform an action or movement)*

1) Putting on your socks or tights without help or aids (eg, sock aid)
EASY_____ IMPOSSIBLE

2) Bending forward from the waist to pick up a pen from the floor without an aid
EASY_____ IMPOSSIBLE

3) Reaching up to a high shelf without help or aids (eg, helping hand)
EASY_____ IMPOSSIBLE

4) Getting up out of an armless dining room chair without using your hands or any other help
EASY_____ IMPOSSIBLE

5) Getting up off the floor without help from lying on your back
EASY_____ IMPOSSIBLE

6) Standing unsupported for 10 minutes without discomfort
EASY_____ IMPOSSIBLE

7) Climbing up 12 - 15 steps without using a handrail or walking aid. One foot on each step
EASY_____ IMPOSSIBLE

8) Looking over your shoulder without turning your body
EASY_____ IMPOSSIBLE

9) Doing physically demanding activities (eg, physiotherapy exercises, gardening, or sports)
EASY_____ IMPOSSIBLE

10) Doing a full day's activities whether it be at home or at work
EASY_____ IMPOSSIBLE

9. Surgery

Have you ever had surgery in any of your joints? yes | no

If yes, what surgery (in which part of your body)

_____

10. Treatment

a) Are you currently taking any medication for your disease? yes | no

If "YES" are you taking

Pain killers	
Non-steroidal anti-inflammatory drugs	
Steroids	
Sulphasalazine	
Methotrexate	
Leflunomide	
Cyclosporine	
Anti TNF	

b) Place a vertical mark (eg, ___/____) on the scale below to indicate the effectiveness that treatment has on relieving your symptoms:

NONE _____VERY EFFECTIVE

11. WELLBEING

a) Place a vertical mark on the scale below to indicate the effect your disease has had on your well-being over the last week:

NONE _____WORST POSSIBLE

b) Place a vertical mark on the scale below to indicate the effect your disease has had on your well-being over the last six months:

NONE _____ WORST POSSIBLE

12. Dietary habits *(Please delete appropriately or circle the right one for you)*

a) Are you a vegan? (eating plant products ONLY) Yes / No

b) Are you vegetarian? Yes / No

If YES, do you eat any of the following?

Eating fish Yes/No

Eating chicken Yes/No

Eating eggs Yes/No

Dairy products Yes/No

c) Do you eat fish or fish produce (ie fish oils) at least once a week Yes/No
d) Do you think any foods aggravate your joint disease? Yes /No

If Yes, any of the foods below:

Meat produce	
Dairy produce	
Lentils/Pulses/beans	
Fruits	
Alcohol	
Fish	
Carbohydrates (ie rice, potato, bread)	
Other	

e) Do you think that any food helps your disease? Yes/No

If yes, what

_____

13.Education/ Occupation/Employment

a) What level of education have you reached? (*Please tick each relevant box*)

No school	
Primary school	
Secondary school	
College or technical skills	
Higher education	

b) Are you currently employed? (incl. self-employed) YES / NO

c) Is your occupation:

Manual	
Active (moving)	
Sedentary (sitting)	
Housewife	
Student / artist	

d) If not employed, are you

Unemployed and intending to work	
Retired	
Unemployed and unable to work	

Are you UNEMPLOYED / RETIRED:

Solely because of your disease?	
Partly because of your disease?	
For reasons other than your disease?	

14. Spondyloarthropathy Group

1a) Have you ever seen a rheumatologist (a specialist in arthritis)? YES/NO

1b) Have you ever been tested for HLA-B27 (a gene usually associated with ankylosing spondylitis)?

YES/NO

1c) If yes, was the result:

Positive	
Negative	
I don't know	

2. IRITIS / UVEITIS

a) Do you get iritis (uveitis)? YES/NO

b) If YES, who made the diagnosis?

GP	
Rheumatologist	
Eye specialist	
No doctor	

c) Have you had any treatment for it? YES/NO

Please specify: _____

d) When did your first symptom of iritis start?

Year: Age:

e) Has the uveitis resulted in persistent deterioration of vision? YES/NO

3. PSORIASIS

a) Do you get psoriasis? YES/NO

b) If YES, who made the diagnosis?

GP	
Rheumatologist	
Skin specialist	
No doctor	

c) Have you ever had any treatment for it? YES/NO

Please specify (what): _____

d) When did your first symptom of psoriasis start?

Year: Age:

e) Have you ever had sausage-like fingers YES/NO

f) Do you have (or ever had) funny nails? YES/NO

4. ENTEROPATHIC SPONDYLOARTHROPATHIES

1. Have you ever been diagnosed as having:
   a) Crohn's disease YES/NO
   b) Ulcerative colitis YES/NO
2. If YES, who made the diagnosis?

	(a)	(b)
GP		
Rheumatologist		
Gastroenterologist		
No doctor		

3. When did your first symptom of bowel disease start?

Year: Age:

15. Family HISTORY

a) Are you married ☐ single ☐ divorced ☐ live with partner ☐ widowed ☐

b) Were your parents blood related in any way prior to marriage? Yes ☐ No ☐

c) If yes what was the relationship prior to marriage? _____

d) Do you have any children? Y ☐ No ☐ any ☐

If yes
e) Please put down ages and gender (M=male or F=female) of children.

Age _____ Sex_____ Age _____ Sex _____ Age _____ Sex _____

Age _____ Sex _____ Age _____Sex _____ Age _____Sex _____

f) Do you have any brothers or sisters? Y ☐ N ☐
If yes, please put down their ages and gender

Age _____ Sex_____ Age _____ Sex _____ Age _____ Sex _____

Age _____ Sex _____ Age _____Sex _____ Age _____Sex _____

g) As far as you know do any other members of your family have any form of spondyloarthropathy, like:
Ankylosing spondylitis, Psoriatic arthritis, reactive arthritis, ulcerative colitis, or Crohn's disease?
Yes ☐ No ☐

Does anybody in your family suffer with **psoriasis** (flaky skin)? YES/NO

If yes, what is the relationship to you? _____

Does anybody in the family suffer from **longstanding lower back pain**? YES/NO

If yes, what is the relationship to you? _____

Thank you for taking your time to fill in this questionnaire!