

HEALTH ASSESSMENT QUESTIONNAIRE

In this section we are interested in learning how your illness affects your ability to function in daily life. Please feel free to add comments.

Please check the one response that best describes your usual abilities

IN THE PAST SEVEN DAYS:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
DRESSING & GROOMING				
Are you able to:				
- Dress yourself, including tying shoelaces and doing buttons	_____	_____	_____	_____
- Shampoo your hair?	_____	_____	_____	_____
ARISING				
Are you able to:				
- Stand up from an armless straight chair?	_____	_____	_____	_____
- Get in and out of bed?	_____	_____	_____	_____
EATING				
Are you able to:				
- Cut your meat?	_____	_____	_____	_____
- Lift a full glass to your mouth?	_____	_____	_____	_____
- Open a new milk carton?	_____	_____	_____	_____
WALKING				
Are you able to:				
- Walk outdoors on flat ground?	_____	_____	_____	_____
- Climb up five stairs?	_____	_____	_____	_____

Please check any **AIDS or DEVICES** that you usually use for any of these activities:

___ Cane	___ Devices for dressing (button hook, zipper pull, long-handled shoe horn, etc.)
___ Walker	___ Built up or special utensils
___ Crutches	___ Special or built-up chair
___ Wheelchair	___ Other (specify: _____)

Please check any categories for which you usually need **ASSISTANCE FROM ANOTHER PERSON:**

_____ Dressing and grooming	_____ Eating
_____ Arising	_____ Walking

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Please check the one response that best describes your usual abilities
IN THE PAST SEVEN DAYS:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
HYGIENE				
Are you able to:				
- Wash and dry your entire body?	_____	_____	_____	_____
- Take a tub bath?	_____	_____	_____	_____
- Get on and off the toilet?	_____	_____	_____	_____
REACH				
Are you able to:				
- Reach and get down a 2.5kg object (such as a bag of sugar) from just over your head?	_____	_____	_____	_____
- Bend down and pick up clothing off the floor?	_____	_____	_____	_____
GRIP				
Are you able to:				
- Open car doors?	_____	_____	_____	_____
- Open jars that have been previously opened?	_____	_____	_____	_____
- Turn faucets on and off?	_____	_____	_____	_____
ACTIVITIES				
Are you able to:				
- Run errands and shop?	_____	_____	_____	_____
- Get in and out of a car?	_____	_____	_____	_____
- Do chores such as vacuuming or yardwork?	_____	_____	_____	_____

Please check any **AIDS or DEVICES** that you usually use for any of these activities:

___ Raised Toilet Seats

___ Bathtub Bar

___ Bathtub Seat

___ Long-Handled Appliances for Reach

___ Jar Opener (for jars previously opened)

___ Long-Handled Appliances in Bathroom

Other (specify: _____)

Please check any categories for which you usually need **HELP FROM ANOTHER PERSON**:

___ Hygiene

___ Gripping and Opening Things

___ Reach

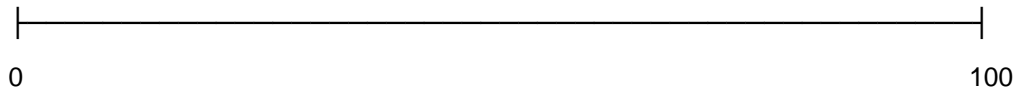
___ Errands and Chores

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 A MARK ON THE LINE TO INDICATE THE SEVERITY OF THE PAIN.

NO PAIN

VERY SEVERE PAIN



IN THE PAST WEEK, how much have your intestinal problems interfered with your daily activities?

PLACE A MARK ON THE LINE TO INDICATE THE LIMITATION OF ACTIVITY.

DO NOT LIMIT ACTIVITIES

VERY SEVERE LIMITATION

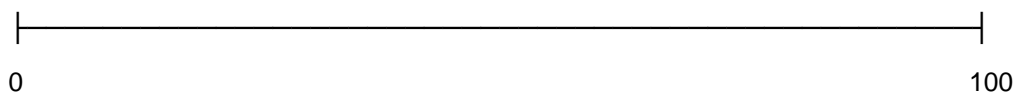


IN THE PAST WEEK, how much have your breathing problems interfered with your daily activities?

PLACE A MARK ON THE LINE TO INDICATE THE LIMITATION OF ACTIVITY.

BREATHING PROBLEMS
DO NOT LIMIT ACTIVITIES

VERY SEVERE
LIMITATION

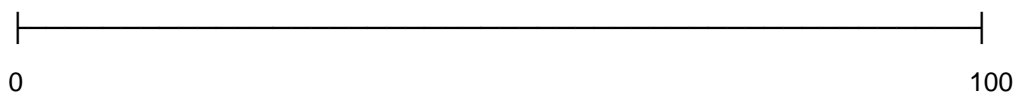


IN THE PAST WEEK, how much has Raynaud's interfered with your daily activities?

PLACE A MARK ON THE LINE TO INDICATE THE LIMITATION OF ACTIVITY.

RAYNAYD'S DOES
NOT LIMIT ACTIVITIES

VERY SEVERE
LIMITATION

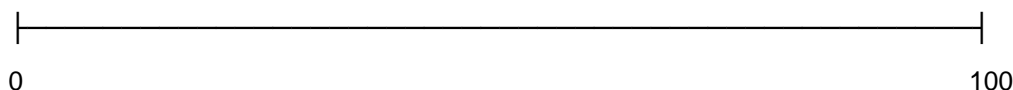


IN THE PAST WEEK, how much have your finger ulcers interfered with your daily activities?

PLACE A MARK ON THE LINE TO INDICATE THE LIMITATION OF ACTIVITY.

FINGER ULCERS
DO NOT LIMIT ACTIVITIES

VERY SEVERE
LIMITATION

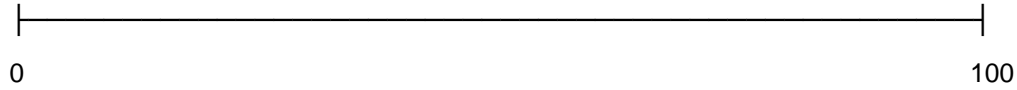


Overall, considering how much pain, discomfort, limitations in your daily life and other changes in your body and life, how severe would you rate your disease today?

PLACE A MARK ON THE LINE TO INDICATE THE LIMITATION OF ACTIVITY.

NO DISEASE

VERY SEVERE
LIMITATION



Steen VD, Medgers TA. The Value of the Health Assessment Questionnaire and special patient-generated scales to demonstrate change in systemic sclerosis patients over time. *Arthritis Rheum* 1997 Nov ; 40 (11):1984–1991.