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:

<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>
</table>

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

Please check any categories for which you usually need ASSISTANCE FROM ANOTHER PERSON:
- [ ] Dressing and grooming
- [ ] Eating
- [ ] Arising
- [ ] Walking
HEALTH ASSESSMENT QUESTIONNAIRE, cont.

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

<table>
<thead>
<tr>
<th></th>
<th>Without ANY difficulty</th>
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<th>With MUCH difficulty</th>
<th>UNABLE to do</th>
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</table>

**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 5 pound 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.*

<table>
<thead>
<tr>
<th>NO PAIN</th>
<th>VERY SEVERE PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>INTESTINAL PROBLEMS</th>
<th>VERY SEVERE LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO NOT LIMIT ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>BREATHING PROBLEMS</th>
<th>VERY SEVERE LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO NOT LIMIT ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>RAYNAUD’S DOES</th>
<th>VERY SEVERE LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOT LIMIT ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>100</td>
</tr>
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</table>

**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.*

<table>
<thead>
<tr>
<th>FINGER ULCERS</th>
<th>VERY SEVERE LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO NOT LIMIT ACTIVITIES</td>
<td></td>
</tr>
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</table>

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.*

<table>
<thead>
<tr>
<th>NO DISEASE</th>
<th>VERY SEVERE LIMITATION</th>
</tr>
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<td>100</td>
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