

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ)[†]

DISABILITY INDEX WITH PAIN AND FATIGUE SCALES

PATIENT'S INITIALS

DATE OF BIRTH (DD/MM/YY)

TODAY'S DATE (DD/MM/YY)

In this section, we are interested in learning how your rheumatoid arthritis (RA) affects your ability to function in daily life. Please feel free to add any comments.

Please check the response which best describes your usual abilities OVER THE PAST WEEK:

	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 up buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARISING				
Are you able to:				
■ Stand up from a chair without armrests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EATING				
Are you able to:				
■ Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING				
Are you able to:				
■ Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
■ Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the activities mentioned above:

- | | |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.) |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Specially adapted utensils (such as for eating, cooking) |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Specially adapted chair |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Other (specify): _____ |

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

- | | |
|------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Dressing and grooming | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Arising | <input type="checkbox"/> Walking |

[†]© Stanford University (with exception of fatigue scale).

Please also complete reverse side.

Please check the response which best describes your usual abilities OVER THE PAST WEEK:

	Without ANY difficulty	With SOME difficulty	With MUCH difficulty	UNABLE to do
HYGIENE				
Are you able to:				
<input type="checkbox"/> Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Take a bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACH				
Are you able to:				
<input type="checkbox"/> Reach and get down a 2.5-kg object (such as a bag of sugar) from just above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GRIP				
Are you able to:				
<input type="checkbox"/> Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Open jars which have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Turn water faucets/taps on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTIVITIES				
Are you able to:				
<input type="checkbox"/> Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the activities mentioned above:

<input type="checkbox"/> Raised toilet seat	<input type="checkbox"/> Bathtub bar
<input type="checkbox"/> Bathtub seat	<input type="checkbox"/> Long-handled appliances for reach
<input type="checkbox"/> Jar opener (for jars previously opened)	<input type="checkbox"/> Long-handled appliances in bathroom (such as a brush for washing yourself)
<input type="checkbox"/> Other (specify): _____	

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

<input type="checkbox"/> Hygiene	<input type="checkbox"/> Gripping and opening things
<input type="checkbox"/> Reach	<input type="checkbox"/> Errands and chores

We are interested in learning whether or not you are affected by pain because of your RA.

How much pain have you had because of your illness IN THE PAST WEEK:

Place a vertical mark (|) on the line to indicate the severity of the pain.

0	_____	50	_____	100
		No pain		Severe pain

We are also interested in learning whether or not you are affected by fatigue.

How much fatigue have you had IN THE PAST WEEK:

Place a vertical mark (|) on the line to indicate the severity of the fatigue.

0	_____	50	_____	100
		No fatigue		Severe fatigue

Considering all the ways your arthritis affects you:

Place a vertical mark (|) on the line to indicate overall how well you are doing.

0	_____	50	_____	100
		Disease not active		Disease active