Subject Initials ☐☐☐ **Subject No.** ☐☐☐☐ **Date** _____/_____/_____

1.1.PART 1 BASELINE QUESTIONNAIRE FOR PARTICIPANTS

CCP – NEXT GENERATION: CO-ORDINATED PROGRAMME TO PREVENT ARTHRITS: CAN WE IDENTIFY PATIENTS AT A PRE-CLINICAL STAGE?

NAME:_____ Date: _____

Date of birth: _____

Contact Telephone No:

Address:

E-mail address:

GP name:

GP address:

Who has referred you to this study? *Please tick the relevant box and provide details:*

Your GP ☐ Other health professionals (e.g. physiotherapist, podiatrist) ☐

A relative who has rheumatoid arthritis ☐ Other ☐

Please provide details of your referrer:

(Name and address if different from GP address above):

How would you like to receive the 12 month questionnaire?

By email ☐ By post ☐

Have you been referred to this study because you have a new muscle or joint pain

YES ☐ NO ☐

OR because are you a first degree relative (mother, father, brother, sister, son or daughter) of someone with rheumatoid arthritis?

YES ☐ NO ☐

Subject Initials ☐☐☐ **Subject No.** ☐☐☐☐ **Date**_____/_____/_____

Does anyone in your family have rheumatoid arthritis?

YES ☐ NO ☐

- If **YES**, how is the person(s) related to you?

Mother ☐ Father ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐

Other ☐ (please specify) _____

- Are they being treated in the Chapel Allerton Hospital Rheumatology Department in Leeds?

  YES ☐ NO ☐

Have you been given a diagnosis for your new muscle or joint pain?

YES ☐ NO ☐ N/A ☐

- If **YES**, what is the diagnosis? _____

Have you ever been diagnosed by either your GP or a Specialist with:
(Please tick all that apply and write the date beside any ticked boxes)

		Date:
Carpal tunnel syndrome	☐	_____
Trigger finger	☐	_____
Osteoarthritis	☐	_____
Rheumatoid arthritis	☐	_____
Psoriasis	☐	_____
Psoriatic arthritis	☐	_____
Fibromyalgia	☐	_____
Polymyalgia rheumatica	☐	_____
Other (please specify): _____	☐	_____

Subject Initials ☐☐☐ **Subject No.** ☐☐☐☐ **Date**_____/_____/_____

When are your symptoms worse?

Morning ☐ Afternoon ☐ Night ☐ Same throughout the day ☐

Do you have any stiffness when you wake up in the morning?

Yes ☐ No ☐

If **YES**, how long does it last before it wears off? (If it never goes completely, how long does it last until it begins to ease?)

☐☐ Hours ☐☐ Minutes

Do you have any difficulty making a fist?

Yes ☐ No ☐

Do you smoke?

Yes ☐ No ☐

If no, have you ever smoked?

Yes ☐ No ☐

If you have ever smoked, how many cigarettes per day did or do you smoke?

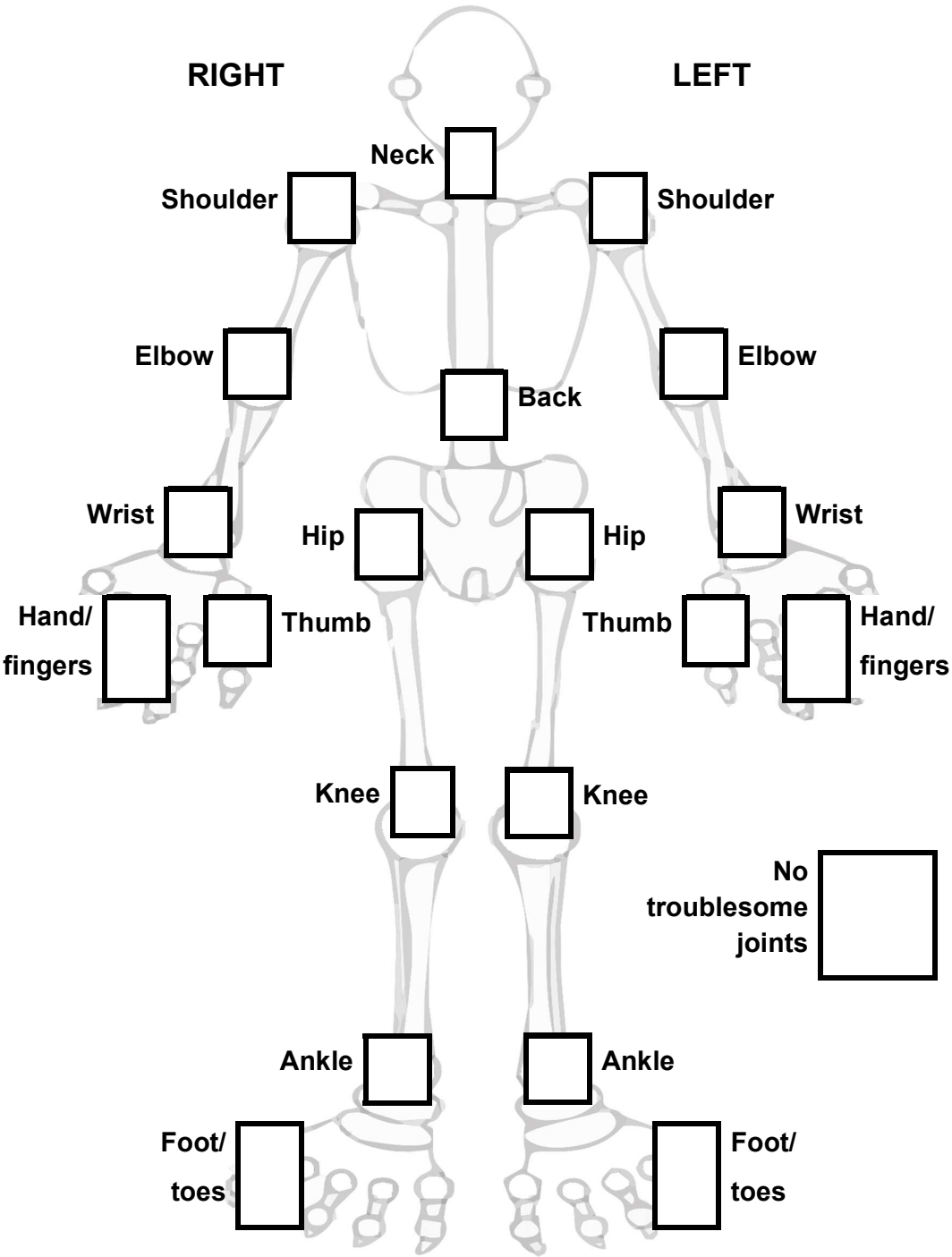
_____

And for how many years?

_____

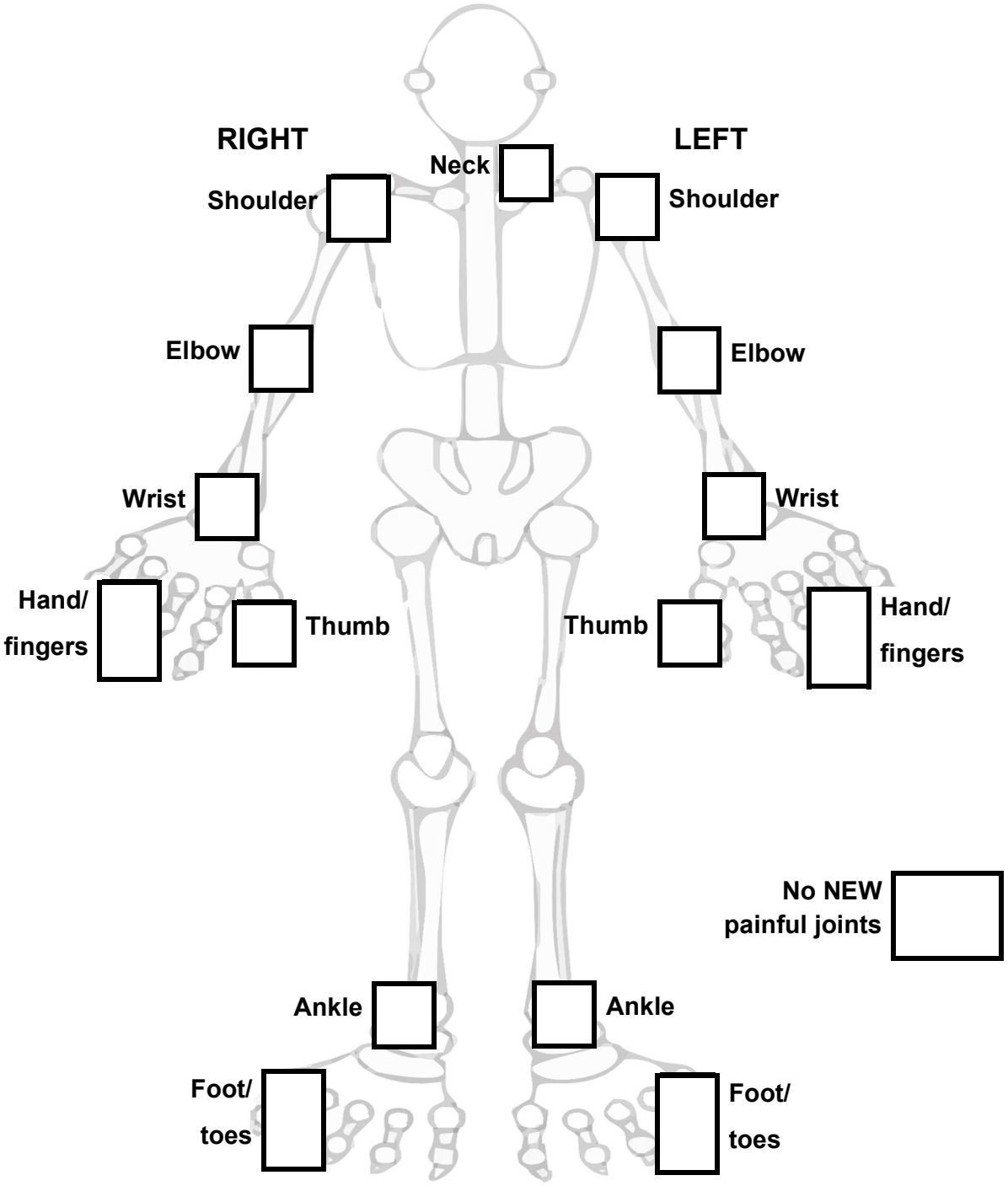
Subject Initials ☐☐☐ **Subject No.** ☐☐☐☐ **Date**_____/_____/_____

1. Please look at the chart below and **tick** ☑ all of your joints which are painful or troublesome.



Subject Initials ☐☐☐ **Subject No.** ☐☐☐☐ **Date**_____/_____/_____

2. Please look at the chart below and **circle** the area(s) of **NEW** (joint) pain. (i.e. the reason you saw your GP or health professional)



Thank you very much for your time to complete this questionnaire