



Subject Contact Information

Name: _____
Last First Middle name or initial Suffix

Street Address/P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Telephone No.: (____) _____ - _____ Alternate Telephone No.: (____) _____ - _____

E-mail address: _____

Additional Contact Information

Provide two additional contacts including the guardian of the subject as one. If subject is less than 18, at least one of the contacts should be residing at a different address than the subject.

Name	Relationship	Guardian	Address	Telephone No.	E-mail Address
1 Primary (<i>guardian if applicable</i>): Last: _____ First: _____ Middle: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (<i>specify</i>): _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Same as above _____ <small>Street/PO Box</small> _____ <small>City State Zip Code</small>	<input type="checkbox"/> Same as above (____) _____ - _____ Alternate phone no.: (____) _____ - _____ OR <input type="checkbox"/> NA	_____ @ _____ OR <input type="checkbox"/> Not done
2 Last: _____ First: _____ Middle: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (<i>specify</i>): _____		<input type="checkbox"/> Same as above _____ <small>Street/PO Box</small> _____ <small>City State Zip Code</small>	<input type="checkbox"/> Same as above (____) _____ - _____ Alternate phone no.: (____) _____ - _____ OR <input type="checkbox"/> NA	_____ @ _____ OR <input type="checkbox"/> Not done
3 Last: _____ First: _____ Middle: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (<i>specify</i>): _____		<input type="checkbox"/> Same as above _____ <small>Street/PO Box</small> _____ <small>City State Zip Code</small>	<input type="checkbox"/> Same as above (____) _____ - _____ Alternate phone no.: (____) _____ - _____ OR <input type="checkbox"/> NA	_____ @ _____ OR <input type="checkbox"/> Not done

Family History**1 Does the biologic mother, father, or any sibling have history of the following diseases?** Yes → If Yes: Check all that apply:

- Systemic lupus erythematosus
- Juvenile idiopathic arthritis/juvenile rheumatoid arthritis
- Fibromyalgia
- Rheumatoid arthritis
- Psoriasis
- Multiple sclerosis
- Ankylosing spondylitis
- Autoimmune thyroiditis (including Graves' and Hashimoto's)
- Spondyloarthropathy
- Celiac disease
- Crohn's disease or ulcerative colitis
- Diabetes Type 1
- Acute anterior uveitis
- Other autoimmune disease

 No Unknown**2 Does subject have any biologic sisters (full or half)?** Yes No Unknown**3 Does subject have any biologic brothers (full or half)?** Yes No Unknown



Demographics and Disease Characteristics

1 Date of birth: ____/____/____
month day year

2 Ethnicity (check all that apply):

- Hispanic or Latino
 Not Hispanic or Latino

3 Race (check all that apply):

- White Asian
 Black or African American Native Hawaiian or other Pacific Islander
 American Indian or Alaska Native Unknown or do not wish to provide

4 Gender (check only one):

- Male
 Female

5 Household income (in US \$ - annual gross) (check only one):

- < 25,000 100–150,000
 25–49,999 above 150,000
 50–74,999 Unknown
 75–99,999

6 Country of primary residence at onset of disease symptoms:

- United States: Zip Code: _____
 Canada: Postal Code: _____
 Other country (specify): _____
 Unknown or do not wish to provide

7 Antinuclear antibody test (ANA):

- Positive
 Negative
 Not done

8 What is the subject's rheumatologic disease diagnosis? (If multiple, please select those that meet disease classification criteria.)

- Mixed connective tissue disease
 Systemic lupus erythematosus
 Primary Sjögren's disease
 Systemic sclerosis
 Juvenile dermatomyositis
 Localized scleroderma
 Juvenile idiopathic arthritis/juvenile ankylosing spondylitis
 Chronic vasculitis (excluding Kawasaki and Henoch-Schönlein purpura)
 Sarcoid
 Auto-inflammatory disease (including fever syndromes, chronic recurrent multifocal osteomyelitis)
 Idiopathic uveitis (not associated with other rheumatologic disease)
 Juvenile primary fibromyalgia

9 Month and year of onset of disease symptoms (record UNK for unknown day or month, make best estimate of year):

____/____/____
month day year

10 Date first seen by pediatric rheumatologist (record UNK for unknown day or month, make best estimate of year):

____/____/____
month day year

Demographics and Disease Characteristics (continued)**11 Does the subject have any of the following pre-existing conditions:** Yes: **Check all that apply:**

- Autism spectrum disorder
- Auto-immune hepatitis
- Auto-immune thyroid disease
- Celiac disease
- Cerebral palsy
- Chronic asthma
- Congenital heart disease
- Cystic fibrosis
- Demyelinating disease
- Diabetes – Type 1
- Diabetes – Type 2
- Malignancy
- Primary immunodeficiency syndrome(s)
- Seizure disorder
- Trisomy-21
- Other autoimmune disease (*specify*): _____
- Other major congenital or acquired disease/condition (*specify*): _____

 No Unknown**12 ACR Functional Class worst ever (from Baseline Physician's Worksheet) (check only one):**

- Class I (*completely able to perform usual daily activities*)
- Class II (*able to perform usual self-care and vocational activities, but limited in avocational activities*)
- Class III (*able to perform usual self-care activities, but limited in vocational and avocational activities*)
- Class IV (*limited ability to perform usual self-care, vocational, and avocational activities*)
- Not done
- Unknown



Visit date: ____/____/____
 day month year

Subject Data

- 1 Height: _____ . ____ cm OR Not done
- 2 Weight: _____ . ____ kg OR Not done
- 3 Blood pressure: _____ / _____ OR Not done
- 4 Does the subject smoke? Yes No Unknown
- 5. Does anyone else in the subject's household smoke? Yes No Unknown

Insurance Status

- Does subject have health insurance?
- Yes
 - No
 - Unknown

Health Related Quality of Life Score (from Parent/Subject Worksheets)

Score (check only one): Excellent Very good Good Poor Very poor OR Not done

Parent/Subject Assessments (from Parent/Subject Worksheets)

- Overall well-being score: _____ OR Not done
- Pain score (Parent completes if subject <4; Subject completes if >9): _____ OR Not done OR Not applicable at this age
- Faces Pain Scale score (subject 4-9 years old): _____ OR Not applicable at this age OR Not done

CHAQ (from Parent/Subject Worksheet)

CHAQ disability index score: _____ OR Not done

Physician Global Assessment (from Baseline Physician Worksheet)

Score: _____ OR Not done

ACR Functional Class Current (from Baseline Physician Worksheet)

- Check only one:
- Class I (completely able to perform usual daily activities)
 - Class II (able to perform usual self-care and vocational activities, but limited in avocational activities)
 - Class III (able to perform usual self-care activities, but limited in vocational and avocational activities)
 - Class IV (limited ability to perform usual self-care, vocational, and avocational activities)
 - Not done
 - Unknown



Parent/Subject Questionnaires

Date completed: ____/____/____
month day year

Person completing form: Mother Father Subject Other (specify): _____

Parent

1 How do you rate your child's health? Excellent Very good Good Poor Very poor

2 Considering all the ways that your child's rheumatic condition affects your child, rate how your child is doing:

0 1 2 3 4 5 6 7 8 9 10
Very Very
Well Poor

Please circle one number

3 We are also interested in learning whether or not your child has been affected by pain because of his/her rheumatic condition.

How much pain do you think your child had because of his/her rheumatic condition in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Very Severe
Pain Pain

Please circle one number

OR Subject

1 How do you rate your health? Excellent Very good Good Poor Very poor

2 Considering all the ways that your rheumatic condition affects you, rate how you are doing:

0 1 2 3 4 5 6 7 8 9 10
Very Very
Well Poor

Please circle one number

3 We are also interested in learning whether or not you have been affected by pain because of your rheumatic condition.

How much pain have you had because of your rheumatic condition in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Very Severe
Pain Pain

Please circle one number

Faces Pain Scale – Revised (FPS-R)

In the following instructions, say "hurt" or "pain," whichever seems right for a particular child.

"These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] - it shows very much pain. Point to the face that shows how much you hurt [right now]."

Score the chosen face **0, 2, 4, 6, 8, or 10**, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how children feel inside, not how their face looks.

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Sources. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. *Pain* 2001;93:173-183. Bieri D, Reeve R, Champion GD, Addicoat L, Ziegler J. The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation and preliminary investigation for ratio scale properties. *Pain* 1990;41:139-150.

10

8

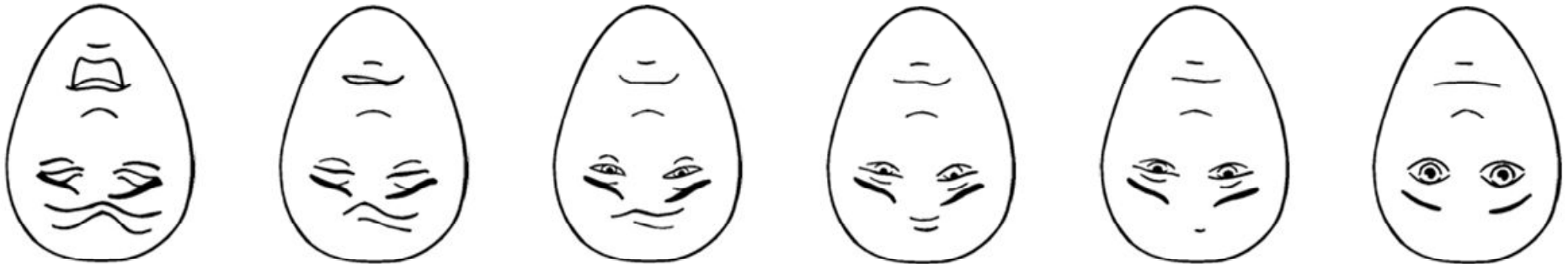
6

(fold along dotted line)

4

2

0





Childhood Health Assessment Questionnaire (CHAQ)

Instructions

In this section we are interested in learning how your child's illness affects his/her ability to function in daily life. Please feel free to add any comments on the back of this page. In the following questions, please check the one response that best describes your child's usual activities (averaged over an entire day) **OVER THE PAST WEEK.** **ONLY NOTE THOSE DIFFICULTIES OR LIMITATIONS THAT ARE DUE TO ILLNESS.** If most children at your child's age are not expected to do a certain activity, please mark it as "Not Applicable." **For example, if your child has difficulty in doing a certain activity or is unable to do it because he/she is too young but not because he/she is RESTRICTED BY ILLNESS, please mark it as "Not Applicable."**



CHAQ Functional Ability Scoring and Coding

(Adapted from the scanned instructions received from Dr. Nicola Ruperto)

The DAILY FUNCTION section is designed to assess the patient's functional ability over the past week. It is composed of eight categories, each of which has at least two component questions. Parents are also asked to indicate the use of any aids or devices or if the child needs help from another person for any of these activities. The eight categories are: dressing & grooming, arising, eating, walking, hygiene, reach, grip, and activities.

Possible responses for the component questions are:

- Without ANY difficulty = 0
- With SOME difficulty = 1
- With MUCH difficulty = 2
- UNABLE to do = 3

The highest score for any component question determines the score for that category. If a component question is left blank or the response is too ambiguous to assign a score, then the score for the category is determined by the remaining completed question(s). If all component questions are blank/not applicable, then the category is not scored and not used in the calculation of the final disability index.

If the parent's mark is between the response columns, then move it to the closest one. If it's directly between the two, move it to the higher one.

If either devices and/or help from another person is checked for a category, the score=2. This may determine the score unless the score on any other component question=3. For example, the response to "Dress yourself..." is with SOME difficulty (score=1). The parent has checked the use of a device for dressing, thereby increasing the score to 2. The response to "Shampoo your hair" is UNABLE to do (score=3). Therefore, the score for the DRESSING category is 3.

Devices associated with each category:

- DRESSING & GROOMING Devices used for dressing (button hook, zipper pull, long handles shoe horn, etc.)
- ARISING Built up or special chair
- EATING Built up pencil or special utensils
- WALKING Cane, walker, crutches, wheelchair
- HYGIENE Raised toilet set, bathtub seat, bathtub bar, long-handled appliances in bathroom
- REACH Long-handled appliances for reach
- GRIP Jar opener (for jars previously opened)

Devices written in the "Other" sections are considered only if they would be used for any of the stated categories.

Disability Index Calculation

The index is calculated by adding the scores for each of the categories and dividing by the number of categories answered. If questions in each category were answered, divide by 8. This gives a score in the 0 to 3.0 range.

Scoring worksheet:

- | | |
|---------------------------------|----------------------|
| 1. Dressing and Grooming: _____ | 5. Hygiene: _____ |
| 2. Arising: _____ | 6. Reach: _____ |
| 3. Eating: _____ | 7. Grip: _____ |
| 4. Walking: _____ | 8. Activities: _____ |

Add scores from 1-8 above to get TOTAL: _____

Divide above TOTAL by number of answered categories to get Disability Index (0.00-3.00):

____ . ____ ____

Enter value in the above box for CHAQ score



Childhood Health Assessment Questionnaire (CHAQ)

Date completed: ____/____/____
month day year

Person completing form: Mother Father Subject Other (specify): _____

	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do	Not Applicable
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Dressing and Grooming: Is your child able to...

Dress, including tying shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo his/her hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove socks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cut fingernails?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Arising: Is your child able to...

Stand up from a low chair or floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed or stand up in a crib?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eating: Is your child able to...

Cut his/her own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift up a cup or glass to mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new cereal box?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Walking: Is your child able to...

Walk outdoors on flat ground?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

Please check any AIDS or DEVICES that your child usually uses for any of the above activities:

Cane	<input type="checkbox"/>	Devices used for dressing (button hook, zipper pull, long-handled shoe horn, etc.)	<input type="checkbox"/>
Walker	<input type="checkbox"/>	Built up pencil or special utensils	<input type="checkbox"/>
Crutches	<input type="checkbox"/>	Special or built up chair	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>

Please check any categories for which your child usually needs help from another person BECAUSE OF ILLNESS:

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

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Childhood Health Assessment Questionnaire (CHAQ)					
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do	Not Applicable
Hygiene: Is your child able to...					
Wash and dry entire body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a tub bath (get in and out of tub)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet or potty chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comb/brush hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach: Is your child able to...					
Reach and get down a heavy object such as a large game or books from just above his/her head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing or a piece of paper from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull on a sweater over his/her head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn neck to look back over shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grip: Is your child able to...					
Write or scribble with pen or pencil?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open jars that have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push open a door when he/she has to turn a door knob?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities: Is your child able to...					
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 or toy car or school bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ride bike or tricycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do household chores (e.g., wash dishes, take out trash, vacuuming, yard work, make bed, clean room)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run and play?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please check any AIDS or DEVICES that your child usually uses for any of the above activities:					
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	<input type="checkbox"/>		
Please check any categories for which your child usually needs help from another person BECAUSE OF ILLNESS:					
Hygiene	<input type="checkbox"/>	Gripping and opening things	<input type="checkbox"/>		
Reach	<input type="checkbox"/>	Errand and chores	<input type="checkbox"/>		



Baseline Physician Worksheet

Date completed: ____/____/____
month day year

Rheumatologic Disease Diagnosis

What is the subject's rheumatologic disease diagnosis? (If multiple, please select those that meet disease classification criteria.)

- Mixed connective tissue disease
- Systemic lupus erythematosus
- Primary Sjögren's disease
- Systemic sclerosis
- Juvenile dermatomyositis
- Localized Scleroderma
- Juvenile idiopathic arthritis/Juvenile ankylosing spondylitis
- Chronic vasculitis (excluding Kawasaki and Henoch-Schönlein purpura)
- Sarcoid
- Auto-inflammatory disease (including fever syndromes, chronic recurrent multifocal osteomyelitis)
- Idiopathic uveitis (not associated with other rheumatologic disease)
- Juvenile primary fibromyalgia

Physician Global Assessment of Disease Activity

Instructions: Indicate the assessed level of this subject's disease activity. (To be filled out the **same day** as subject's visit. Do not wait for laboratory results.)

At this time, the overall disease activity is:

Not Active											Very Active
0	1	2	3	4	5	6	7	8	9	10	

Please circle one number

ACR Functional Class

1 ACR functional class worst ever (check only one):

- Class I (completely able to perform usual daily activities)
- Class II (able to perform usual self-care and vocational activities, but limited in avocational activities)
- Class III (able to perform usual self-care activities, but limited in vocational and avocational activities)
- Class IV (limited ability to perform usual self-care, vocational, and avocational activities)
- Not done
- Unknown

2 ACR functional class current (check only one):

- Class I (completely able to perform usual daily activities)
- Class II (able to perform usual self-care and vocational activities, but limited in avocational activities)
- Class III (able to perform usual self-care activities, but limited in vocational and avocational activities)
- Class IV (limited ability to perform usual self-care, vocational, and avocational activities)
- Not done
- Unknown



Medication History

Please indicate all sources of information used to answer medication items below (select all that apply):

- Family or subject recall
 Limited chart review
 Provider recall
 Complete chart review
 Other

Has subject been in any blinded drug trial(s) where treatment assigned has not yet been revealed to physician or subject not yet transitioned to open-label phase?

Yes → Check all that apply:

Current study → Specify drug(s): _____

Past study → Specify drug(s): _____

- No
 Unknown

1 Non-biologic immune modulators and disease-modifying antirheumatic drugs (DMARDs):

No Yes → If Yes: Check one answer per medication

Azathioprine (<i>Imuran</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Cyclophosphamide oral (<i>Cytoxan</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Cyclophosphamide pulse (<i>Cytoxan</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Cyclosporine A (<i>Neoral, Sandimmune, Gengraf</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Hydroxychloroquine (<i>Plaquenil</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Leflunomide (<i>Arava</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Methotrexate—oral	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Methotrexate—subcutaneous	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Mycophenylate mofetil (<i>CellCept, Myfortic</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Sulfasalazine (<i>Azulfidine</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Tacrolimus (<i>Prograf</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Lenalidomide (<i>Revlimid</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Thalidomide (<i>Thalomid</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Colchicine (<i>Colcrys</i>)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown

Current use: Physician has prescribed and another scheduled dose is intended or stopped on day of visit. Do not include drugs newly prescribed at this visit.

Medication History (continued)				
2 Biologics: <input type="checkbox"/> No <input type="checkbox"/> Yes → If Yes: Check one answer per medication				
Abatacept (Orencia)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Adalimumab (Humira)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Anakinra (Kineret)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Belimumab (Benlysta)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Canakinumab (Ilaris)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Certolizumab (Cimzia)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Epratuzumab (LymphoCide)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Etanercept (Enbrel)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Golimumab (Simponi)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Infliximab (Remicade)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
IVIG	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Rilonacept (Arcalyst)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Rituximab (Rituxan)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Tocilizumab (Actemra)	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Other biologic (specify):	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Other biologic (specify):	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
3 Glucocorticoids (other than inhaled and intranasal): <input type="checkbox"/> No <input type="checkbox"/> Yes → If Yes: Check one answer per medication				
Intraarticular corticosteroids	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
IV pulse steroids	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Systemic corticosteroids long term daily	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
If current or prior use, what is cumulative exposure? <input type="checkbox"/> < 1 month <input type="checkbox"/> ≥ 1 month <input type="checkbox"/> Unknown				
Intraocular injections	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
Steroid eye drops	<input type="checkbox"/> Current use	<input type="checkbox"/> Prior use	<input type="checkbox"/> Never	<input type="checkbox"/> Unknown
4 Other drugs of interest				
Daily nonsteroidal anti-inflammatory drugs (NSAIDs)	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Selective serotonin reuptake inhibitors (SSRIs)	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Tri-cyclic antidepressants	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Serotonin norepinephrine reuptake inhibitors (SNRIs)	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Gamma-aminobutyric acid (GABA) analogues	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Opioids	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Cimetidine	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	
Herbals or non-vitamin supplements	<input type="checkbox"/> Current use	<input type="checkbox"/> Not Taking	<input type="checkbox"/> Unknown	

Current use: Physician has prescribed and another scheduled dose is intended or stopped on day of visit. Do not include drugs newly prescribed at this visit.

Juvenile Idiopathic Arthritis/ Juvenile Ankylosing Spondylitis Disease Specific Form
Baseline

1	Physician assigned category (<i>check only one</i>): <input type="checkbox"/> Systemic JIA <input type="checkbox"/> Psoriatic <input type="checkbox"/> Polyarticular RF (-) <input type="checkbox"/> ERA <input type="checkbox"/> Polyarticular RF (+) <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Oligoarticular persistent <input type="checkbox"/> Juvenile Ankylosing Spondylitis (JAS) <input type="checkbox"/> Oligoarticular extended <input type="checkbox"/> Other																																																																																										
2	Total number of joints ever affected with arthritis: <input type="checkbox"/> < 5 joints <input type="checkbox"/> ≥ 5 joints																																																																																										
3	Total number of currently active joints: _____																																																																																										
4	Has subject ever had any of the following disease manifestations (Current = at the current visit or within the last month; Past = not within the last month but has in the past):																																																																																										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Quotidian fever for > 2 weeks AND daily for > 3 days</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Evanescent rash</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Generalized lymphadenopathy</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Hepatomegaly</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Splenomegaly</td> <td><input type="checkbox"/> Current</td> <td><input 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type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown <i>(if Current, complete Baseline Uveitis form)</i></td> </tr> <tr> <td>Pulmonary hypertension</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Rheumatoid nodules</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Interstitial lung disease</td> <td><input type="checkbox"/> Current</td> <td><input type="checkbox"/> Past</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>	Quotidian fever for > 2 weeks AND daily for > 3 days	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Evanescent rash	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Generalized lymphadenopathy	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Hepatomegaly	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Splenomegaly	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Serositis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Nail pitting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Dactylitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Leg length discrepancy	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Psoriasis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Enthesitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Sacroiliac joint tenderness and/or inflammatory lumbosacral pain	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Limited lumbosacral mobility (modified Schober test)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Inflammatory bowel disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Uveitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input 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5	Has the subject ever had any of the following positive diagnostic tests:																																																																																										
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Positive Anti-CCP</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not done</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Positive IgM RF initial</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not done</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Positive IgM RF confirmatory</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not done</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Positive HLAB27</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Not done</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>	Positive Anti-CCP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown	Positive IgM RF initial	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown	Positive IgM RF confirmatory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown	Positive HLAB27	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown																																																																						
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Positive IgM RF confirmatory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown																																																																																							
Positive HLAB27	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown																																																																																							
6a	Has the subject ever had imaging evidence of joint damage (joint narrowing, erosion, ankylosis): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Imaging not done <input type="checkbox"/> Unknown																																																																																										
6b	Has the subject ever had radiographic, CT or MRI evidence of damage, or CT or MRI evidence of active inflammation involving the sacroiliac joint(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Imaging not done <input type="checkbox"/> Unknown																																																																																										
7	Parent/subject assessment of disease activity (from worksheet): _____ OR <input type="checkbox"/> Not done																																																																																										



RHEUMATOLOGIC JOINT ASSESSMENT (page 1 of 2)

Date of visit (dd/mmm/yyyy): ____/____/____	Visit: ____
---	-------------

RIGHT SIDE				UPPER	LEFT SIDE			
Swelling	POM	Tend	LOM	Joint	Swelling	POM	Tend	LOM
				Temp. Mand.				
			N/A	Sterno.clav				N/A
			N/A	Acro. Clav.				N/A
				Shoulder				
				Elbow				
				Wrist				
				MCP I				
				MCP II				
				MCP III				
				MCP IV				
				MCP V				
				PIP I				
				PIP II				
				PIP III				
				PIP IV				
				PIP V				
				DIP II				
				DIP III				
				DIP IV				
				DIP V				

RHEUMATOLOGIC JOINT ASSESSMENT (page 2 of 2)

Date of visit (dd/mmm/yyyy): ____/____/____

RIGHT SIDE				LOWER	LEFT SIDE			
Swelling	POM	Tend	LOM	Joint	Swelling	POM	Tend	LOM
N/A				Hip	N/A			
				Knee				
				Ankle				
N/A				Subtalar	N/A			
				Tarsi				
				MTP I				
				MTP II				
				MTP III				
				MTP IV				
				MTP V				
				Toes (PIP) I				
				Toes (PIP) II				
				Toes (PIP) III				
				Toes (PIP) IV				
				Toes (PIP) V				
NA			N/A	Sacroiliac	N/A			N/A
				Cervical spine	N/A			
				Thoracic spine	N/A			
				Lumbar spine	N/A			

_____ (to be signed by assessor)

Juvenile Dermatomyositis Disease Specific Form — Baseline	
1	JDM category (check one): <input type="checkbox"/> Definite <input type="checkbox"/> Probable <input type="checkbox"/> Amyopathic
2	Childhood Myositis Assessment Scale (CMAS) score (0–52): ____ OR <input type="checkbox"/> Not done
3	Manual muscle test (MMT-8) score (0–80): ____ OR <input type="checkbox"/> Not done
4	Does the subject have any of the following disease manifestations at today's study visit (please answer all questions):
	Symmetric proximal muscle weakness <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not done
	Gottren's sign, papules or heliotrope <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Malar or facial erythema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	V or shawl sign <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Lipodystrophy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Skin ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Periungual telangiectasia (nailfold capillary changes) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Contractures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
5	Has the subject ever had documented evidence of the following (Current = at today's study visit or within the last month; Past = not within the last month but has in the past):
	Calcinosis <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Small joint arthritis <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Large joint arthritis <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Dysphagia or dysphonia <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Muscle enzyme elevation <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Cardiac involvement (check all that apply) <input type="checkbox"/> Current → If Current: Check all that apply: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Decreased cardiac output <input type="checkbox"/> Myocarditis <input type="checkbox"/> Other <input type="checkbox"/> Past → If Past: Check all that apply: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Decreased cardiac output <input type="checkbox"/> Myocarditis <input type="checkbox"/> Other <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	Interstitial lung disease <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
	GI ulceration due to JDM <input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/> Unknown
6	Has the subject ever had any of the following diagnostic assessments:
	Pulmonary function testing (PFTs) <input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased FVC <input type="checkbox"/> Decreased DLCO <input type="checkbox"/> Reversible airway disease <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	MRI consistent with inflammatory muscle disease ever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	EMG consistent with inflammatory myopathy ever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
	Muscle biopsy consistent with inflammatory muscle disease ever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown



CHILDHOOD MYOSITIS ASSESSMENT SCALE (CMAS) SCORING SHEET

1. **HEAD LIFT:**
 0 = Unable 3 = 30-59
 1 = 1-9 sec 4 = 60-119 sec
 2 = 10-29 5 = \geq 2 min
 Score _____

2. **LEG RAISE/TOUCH OBJECT:**
 0 = Unable to lift leg off table.
 1 = Able to clear table, but cannot touch object (examiner's hand).
 2 = Able to lift leg high enough to touch object (examiner's hand).
 Score _____

3. **STRAIGHT LEG LIFT/DURATION:**
 0 = Unable 3 = 30-59 sec
 1 = 1-9 sec 4 = 60-119 sec
 2 = 10-29 sec 5 = \geq 2 min
 Score _____

4. **SUPINE TO PRONE:**
 0 = Unable. Has difficulty even turning onto side; able to pull right arm under torso only slightly or not at all.
 1 = Turns onto side fairly easily, but cannot fully free right arm and is unable to fully assume a prone position.
 2 = Easily turns onto side; has some difficulty freeing arm, but fully frees arm and fully assumes a prone position.
 3 = Easily turns over, fully frees right arm with no difficulty.
 Score _____

5. **SITS-UPS:**
 Hands on thighs, with counterbalance _____
 Hands across chest, with counterbalance _____
 Hands behind head, with counterbalance _____
 Hands on thighs, without counterbalance _____
 Hands across chest, without counterbalance _____
 Hands behind head, without counterbalance _____
 Score (0-6) _____

6. **SUPINE TO SIT:**
 0 = Unable by self.
 1 = Much difficulty. Very slow, struggles greatly, barely makes it.
 Almost unable.
 2 = Some difficulty. Able, but is somewhat slow, struggles some.
 3 = No difficulty.
 Score _____

7. **ARM RAISE/STRAIGHTEN:**
 0 = Cannot raise wrists up to the level of the A-C joint.
 1 = Can raise wrists at least up to the level of the A-C joint, but not above top of head.
 2 = Can raise wrists above top of head, but cannot raise arms straight above head so that elbows are in full extension.
 3 = Can raise arms straight above head so that elbows are in full extension.
 Score _____

8. **ARM RAISE/DURATION:** Can maintain wrists above top of head for:
 0 = Unable 3 = 30-59 sec
 1 = 1-9 sec 4 = \geq 60 sec
 2 = 10-29 sec
 Score _____

9. **FLOOR SIT:** Going from a standing position to a sitting position on the floor:
 0 = Unable. Afraid to even try, even if allowed to use a chair for support. Child fears that he/she will collapse, fall into a sit, or harm self.
 1 = Much difficulty. Able, but needs to hold onto a chair for support during descent. Unable, or unwilling to try if not allowed to use a chair for support.
 2 = Some difficulty. Can go from stand to sit without using a chair for support, but has at least some difficulty during descent. May need Gower's. Descends somewhat slowly and/or apprehensively; may not have full control or balance as maneuvers into a sit.
 3 = No difficulty. Requires no compensatory maneuvering.
 Score _____

10. **ALL FOURS MANEUVER:**
 0 = Unable to go from a prone to an all-fours position.
 1 = Barely able to assume and maintain an all-fours position. Unable to raise head to look straight ahead.
 2 = Can maintain all-fours position with back straight and head raised (so as to look straight ahead). But, cannot creep (crawl) forward.
 3 = Can maintain all-fours, look straight ahead and creep (crawl) forward.
 4 = Maintains balance while lifting and extending one leg.
 Score _____

11. **FLOOR RISE:** Going from a kneeling position on the floor to a standing position:
 0 = Unable, even if allowed to use a chair for support.
 1 = Much difficulty. Able, but needs to use a chair for support. (Unable if not allowed to use a chair.)
 2 = Moderate difficulty. Able to get up without using a chair for support, but needs to place one or both hands on thighs/knees or floor. (Unable without using hands.)
 3 = Mild difficulty. Does not need to place hands on knees, thighs or floor, but has at least some difficulty during ascent.
 4 = No difficulty.
 Score _____

12. **CHAIR RISE:**
 0 = Unable to rise up from chair, even if allowed to place hands on sides of chair seat.
 1 = Much difficulty. Able, but needs to place hands on sides of seat. Unable if not allowed to place hands on sides of seat.
 2 = Moderate difficulty. Able, but needs to place hands on knees/thighs. Does not need to place hands on sides of seat.
 3 = Mild difficulty. Does not need to place hands on seat, knees or thighs but has at least some difficulty during ascent.
 4 = No difficulty.
 Score _____

13. **STOOL STEP:**
 0 = Unable.
 1 = Much difficulty. Able, but needs to place one hand on exam table (or examiner's hand).
 2 = Some difficulty. Able, does not need to use exam table for support, but needs to use hand on knee/thigh.
 3 = Able. Does not need to use exam table or hand on knee/thigh.
 Score _____

14. **PICK-UP:**
 0 = Unable to bend over and pick up pencil off floor.
 1 = Much difficulty. Able, but relies heavily on support gained by placing hands on knees/thighs.
 2 = Some difficulty. Has some difficulty (but not "much-difficulty"). Needs to at least minimally and briefly place hand(s) on knees/thighs for support. Is somewhat slow.
 3 = No difficulty. No compensatory maneuver necessary.
 Score _____

TOTAL CMAS SCORE: _____

The maximum possible total score for the 14 maneuvers is 52

Systemic Sclerosis Disease Specific Form — Baseline

1 Is disease manifestation present at today's study visit? Please answer all questions.	
Skin changes	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Sclerodactyly <input type="checkbox"/> Calcinosis <input type="checkbox"/> Proximal to MCPs <input type="checkbox"/> Proximal to elbow <input type="checkbox"/> Telangiectasia <input type="checkbox"/> Other <input type="checkbox"/> No
Nail-bed capillary abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digital ulceration/gangrene	<input type="checkbox"/> Yes <input type="checkbox"/> No
Raynaud's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Contractures <input type="checkbox"/> Myositis <input type="checkbox"/> Tendinopathy <input type="checkbox"/> Other <input type="checkbox"/> Arthritis <input type="checkbox"/> No
2 Has the subject had any of the following disease manifestations within the last 6 months?	
Pulmonary involvement	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Dyspnea <input type="checkbox"/> Decreased DLCO/hypoxemia <input type="checkbox"/> Parenchymal pulmonary disease <input type="checkbox"/> Restrictive lung disease <input type="checkbox"/> Radiologic or pathologic evidence of fibrosis <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Other <input type="checkbox"/> No
Cardiac disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Pericardial effusion <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Myocardiopathy <input type="checkbox"/> Angina <input type="checkbox"/> Other <input type="checkbox"/> No
Renal disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Abnormal urinary sediment <input type="checkbox"/> Renovascular hypertension <input type="checkbox"/> Elevated creatinine <input type="checkbox"/> Imaging abnormality <input type="checkbox"/> Fibrosis on biopsy <input type="checkbox"/> Other <input type="checkbox"/> No
GI disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Dysphagia <input type="checkbox"/> Documented GERD <input type="checkbox"/> GI dysmotility <input type="checkbox"/> Esophagitis <input type="checkbox"/> Stricture <input type="checkbox"/> Malabsorption <input type="checkbox"/> Other <input type="checkbox"/> No



Systemic Sclerosis Disease Specific Form — Baseline (continued)

3 Results of diagnostic tests ever done:

Positive Anti-Sci70	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-centromere	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-PM/Sci	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Abnormal histology on biopsy of any site	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

Localized Scleroderma Disease Specific Form — Baseline	
1 Localized scleroderma subtype (check all that apply): <input type="checkbox"/> Circumscribed morphea → Check all that apply: <input type="checkbox"/> Superficial <input type="checkbox"/> Deep <input type="checkbox"/> Linear scleroderma → Check all that apply: <input type="checkbox"/> Linear involving trunk/limbs <input type="checkbox"/> Linear involving face/scalp (En coup de saber, Parry-Romberg) <input type="checkbox"/> Generalized morphea <input type="checkbox"/> Pansclerotic morphea <input type="checkbox"/> Eosinophilic fasciitis <input type="checkbox"/> Other	
2 Location of lesions (check all that apply):	<input type="checkbox"/> Scalp <input type="checkbox"/> Chest <input type="checkbox"/> Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Face <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Buttock <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Abdomen <input type="checkbox"/> Other, specify _____
3 Does the subject have any of the following disease manifestations on today's study visit or documented in the last six months? Please answer all questions.	
New lesion(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Extension of previous lesion(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Erythematous/violaceous lesion color	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lesion warmth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin Induration perimeter lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin Thickening center of lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dermal atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subcutaneous atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hyperpigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hypopigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hair loss associated with lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Extremity shortening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Joint contracture	<input type="checkbox"/> Yes → If Yes: Specify number of joints affected: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> >5 <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hemifacial atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4 Does the subject have any extracutaneous manifestations on today's study visit or documented in the last 6 months?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Arthritis <input type="checkbox"/> GI involvement <input type="checkbox"/> Neurological involvement <input type="checkbox"/> Eye involvement <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
5 Has the subject had any abnormal laboratory findings or imaging abnormalities? Please answer all questions below.	
Abnormal CK	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Abnormal aldolase	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Presence of eosinophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Elevated IgG	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
CNS imaging abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
GI study abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown



Juvenile Primary Fibromyalgia Syndrome Disease Specific Form — Baseline

1 Has subject ever met either the ACR or Yunus and Masi criteria for JPFS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2 Has this subject had any of the following symptoms within the last month (please answer all questions)?	
Widespread pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Disordered sleep?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Non-restorative <input type="checkbox"/> Increased sleep latency <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Frequent wakings <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> No, on medication <input type="checkbox"/> Unknown
Frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Irritable bowel syndrome (IBS) symptoms with prior physician diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subjective soft tissue swelling of the extremities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Numbness and tingling of the extremities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by weather?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by stress/anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3 Does subject have hypermobility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4 Has subject participated in organized physical activity since the onset of pain symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes, but curtailed due to pain <input type="checkbox"/> No <input type="checkbox"/> Unknown
5 Has subject ever been diagnosed with depression and/or anxiety disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6 What treatments have been recommended/prescribed/provided by a pediatric rheumatologist to the subject (check all that apply)?	
<input type="checkbox"/> Education regarding fibromyalgia and chronic pain	<input type="checkbox"/> Referral for psychotropic medications
<input type="checkbox"/> Sleep hygiene	<input type="checkbox"/> Pain clinic → Choose type of pain clinic: <input type="checkbox"/> Pediatric pain clinic <input type="checkbox"/> Adult pain clinic
<input type="checkbox"/> Graduated aerobic exercise program	
<input type="checkbox"/> Physical therapy for stretching and strengthening	
<input type="checkbox"/> General counseling	<input type="checkbox"/> Integrative medicine clinic
<input type="checkbox"/> Cognitive behavioral therapy	<input type="checkbox"/> Rehabilitation clinic
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Other
<input type="checkbox"/> Medications	<input type="checkbox"/> None

Juvenile Primary Fibromyalgia Syndrome Disease Specific Form — Baseline (continued)	
7 Did subject pursue these recommendations?	<input type="checkbox"/> None of recommendations were pursued → If None: Indicate reason (check all that apply): <input type="checkbox"/> Services not available <input type="checkbox"/> Insurance would not cover services <input type="checkbox"/> Subject/family not interested <input type="checkbox"/> Only some recommendations were pursued → If Only some: Indicate reason (check all that apply): <input type="checkbox"/> Services not available <input type="checkbox"/> Insurance would not cover services <input type="checkbox"/> Subject/family not interested <input type="checkbox"/> Most or all recommendations were pursued <input type="checkbox"/> Recommendations made today <input type="checkbox"/> Unknown
8 Has subject used other therapies?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Acupuncture/acupressure <input type="checkbox"/> Craniosacral therapy <input type="checkbox"/> Mindfulness/meditation <input type="checkbox"/> Therapeutic massage <input type="checkbox"/> Physical therapy <input type="checkbox"/> Dietary supplements/herbal remedies <input type="checkbox"/> Hypnosis <input type="checkbox"/> Yoga <input type="checkbox"/> Chiropractor <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown

SLE / MCTD / Sjögren's Disease Specific Form — Baseline

1 Check all of the 1997 ACR criteria for Systemic Lupus Erythematosus (SLE) that the subject has ever met (*SLE subjects must meet at least 3*):

- None
- Malar rash
- Discoid rash
- Photosensitivity
- Oral ulcers
- Arthritis
- Serositis (pleuritis or pericarditis)
- Renal disorder
- Neurological disorder (seizures or psychosis)
- Hematological disorder (thrombocytopenia, hemolytic anemia, leukopenia, or lymphopenia)
- Immunological disorder (positive anti-Smith, anti-ds DNA, antiphospholipid or anti-cardiolipin antibodies or lupus anticoagulant)
- Positive ANA

2 Disease manifestation present? (Please answer all questions.)

Seizure*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Psychosis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Organic Brain Syndrome*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Visual Disturbance*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cranial Nerve Disorder*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other neurological manifestation (other than seizure, psychosis, organic brain syndrome, visual disturbance or cranial nerve disorder)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lupus headache*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cerebral vascular accident*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown

* Questions are from SLEDAI; EDC will calculate and display the total score.

SLE / MCTD / Sjögren's Disease Specific Form — Baseline (continued)	
Myositis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sclerodactyly or swollen hands	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Raynaud's	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Esophageal dysmotility	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Vasculitis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Alopecia*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Mucosal ulcers*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
SICCA syndrome	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fever > 38° C*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pleurisy*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pericarditis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
Myocarditis	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown

* Questions are from SLEDAI; EDC will calculate and display the total score.



SLE / MCTD / Sjögren's Disease Specific Form — Baseline (continued)	
Pulmonary involvement	<input type="checkbox"/> Yes, in the last 10 days → If Yes: Check all that apply: <input type="checkbox"/> Decreased adjusted DLCO (diffusion capacity) <input type="checkbox"/> Pneumonitis <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Lung biopsy performed <input type="checkbox"/> Other <input type="checkbox"/> Yes, in the last 11 days thru 6 months → If Yes: Check all that apply: <input type="checkbox"/> Decreased adjusted DLCO (diffusion capacity) <input type="checkbox"/> Pneumonitis <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Lung biopsy performed <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dialysis	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru 6 months <input type="checkbox"/> No <input type="checkbox"/> Unknown
3 Has subject ever had an arterial thrombotic event?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4 Has subject ever had a venous thrombotic event?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5 Has subject ever been diagnosed with coronary heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6 Has subject ever had imaging evidence of avascular necrosis of any joint?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
7 Does subject have renal disease?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Glomerulonephritis <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Interstitial nephritis <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
8 Has subject ever had a renal transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



SLE / MCTD / Sjögren's Disease Specific Form — Baseline (continued)

Biopsies		
9 Has the subject had any non-renal biopsies consistent with disease diagnosis?	<input type="checkbox"/> Yes If Yes: Check all that apply: <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Skin <input type="checkbox"/> Lacrimal gland <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Other
10 Has subject ever had one or more renal biopsies? <input type="checkbox"/> Yes → If Yes: Answer questions below <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Biopsy Date:	WHO Class (I–VI) <i>Check all that apply</i>	And/OR ISN/RPS Class (I–VI) <i>Check all that apply</i>
____ / ____ / ____ <i>month year</i> OR Record "UNK" for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
____ / ____ / ____ <i>month year</i> OR Record "UNK" for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
____ / ____ / ____ <i>month year</i> OR Record "UNK" for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
11 Serologies (Please answer all questions.)		
Positive Anti-Smith (Sm) antibodies (ever)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-RNP antibodies (ever)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-Ro antibodies (ever)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-La antibodies (ever)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive anti-phospholipid antibodies (including anti-cardiolipin antibodies), anti-β2 glycoprotein 1 antibodies or positive lupus anticoagulant (ever)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Anti-double stranded DNA antibodies in the past 10 days?*	<input type="checkbox"/> Yes → If Yes: Was the test positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Has test been performed in the past 6 months? <input type="checkbox"/> Yes → If Yes: Was the test positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown	

SLE / MCTD / Sjögren's Disease Specific Form — Baseline (continued)	
Complement levels (C3, C4, CH50) in the past 10 days?*	<input type="checkbox"/> Yes → If Yes: Are any of the levels below the lower limits of normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Have these tests been performed in the past 6 months? <input type="checkbox"/> Yes → If Yes: Were any of the levels below the lower limits of normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown
12 Cytopenias (in the last 10 days) (Please answer all questions.)	
Anemia hemoglobin (< 11 g/dL)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Leukopenia (< 3000 white blood cells/mm ³ *)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Thrombocytopenia (< 100K platelets/mm ³ *)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
13 Urinalysis and Renal Function Tests (Please answer all questions.)	
Urinary casts*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Hematuria (> 5 red cells)*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Pyuria (> 5 white cells)*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Proteinuria (> 0.5 protein/creatinine ratio or > 500 mg protein/24 h) in last 10 days?*	<input type="checkbox"/> Yes → If Yes: Is this a new onset or increase of > 0.5 protein/creatinine ratio or > 500 mg protein/24h? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Has proteinuria (> 0.5 protein/creatinine ratio pr > 500 mg protein/24h) been present in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Sample from the first void of the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Serum creatinine (most recent)	_____ mg/dL OR <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

* Questions are from SLEDAI; EDC will calculate and display the total score.

Sarcoid Disease Specific Form — Baseline
1 Is disease manifestation present at today's study visit? Please answer all questions.

Lymphadenopathy	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Abdominal/pelvic <input type="checkbox"/> Mediastinal <input type="checkbox"/> Peripheral <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin lesions	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Livedo reticularis <input type="checkbox"/> Macules <input type="checkbox"/> Papules <input type="checkbox"/> Nodules <input type="checkbox"/> Ulcers <input type="checkbox"/> Erythema nodosum <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hepato- or splenomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

2 Has subject had any of the following disease manifestations within the last 6 months?

Pulmonary disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Pleural disease <input type="checkbox"/> Parenchymal pulmonary disease <input type="checkbox"/> Restrictive lung disease <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hepatic involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Uveitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Bone lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Neurologic involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

3 Results of diagnostic tests done at today's study visit or within the last month:

Hypercalcuria or hypercalcemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Elevated ACE	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

4 Has the subject ever had a biopsy with histology consistent with sarcoid?

	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Bone <input type="checkbox"/> Lymph node <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Parotid <input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Kidney <input type="checkbox"/> Synovium <input type="checkbox"/> Liver <input type="checkbox"/> Other <input type="checkbox"/> Biopsies performed, but not consistent with sarcoid <input type="checkbox"/> No biopsies performed <input type="checkbox"/> Unknown
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Vasculitis Disease Specific Form — Baseline	
1 Vasculitis diagnosis (must meet diagnostic criteria) (check only one):	<input type="checkbox"/> Childhood Wegener's Granulomatosis <input type="checkbox"/> Childhood Systemic Polyarteritis Nodosa, systemic <input type="checkbox"/> Childhood Takayasu's Arteritis <input type="checkbox"/> Microscopic Polyangitis <input type="checkbox"/> Primary Central Nervous System Vasculitis <input type="checkbox"/> Cutaneous Polyarteritis Nodosa <input type="checkbox"/> Behcet's Syndrome <input type="checkbox"/> Churg-Strauss Syndrome
2 Which of these is diagnosis based on (check all that apply)?	<input type="checkbox"/> Clinical findings <input type="checkbox"/> Tissue pathology <input type="checkbox"/> Imaging <input type="checkbox"/> Serology <input type="checkbox"/> Other
3 Has subject had any of the following disease manifestations in the last 6 months? Please answer all questions.	
Hypertension (or on chronic antihypertensive medications)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Mucosal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Eye involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Upper respiratory tract involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lower respiratory tract involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal insufficiency	<input type="checkbox"/> Yes → If Yes: Check treatment: <input type="checkbox"/> On dialysis <input type="checkbox"/> Not on dialysis <input type="checkbox"/> Received renal transplant <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Liver involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Intestinal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiovascular involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Central nervous system involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Peripheral nervous system involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Positive c-ANCA or anti-PR3 ever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive p-ANCA or anti-MPO ever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

Autoinflammatory Disease Specific Form — Baseline	
1 Current diagnosis (check all that apply):	<input type="checkbox"/> CH (Cyclic hematopoiesis) <input type="checkbox"/> CINCA (Chronic infantile neurological cutaneous and articular syndrome) / NOMID (Neonatal-onset multisystem inflammatory disease) <input type="checkbox"/> CRMO (Chronic recurrent multifocal osteomyelitis) <input type="checkbox"/> DIRA (Deficiency of interleukin-1 receptor antagonist) <input type="checkbox"/> FCAS(Familial cold autoinflammatory syndrome) <input type="checkbox"/> FMF (Familial Mediterranean fever) <input type="checkbox"/> HIDS (Hyperimmunoglobulin (Ig) D syndrome) <input type="checkbox"/> Majeed syndrome <input type="checkbox"/> MWS (Muckle-Wells syndrome) <input type="checkbox"/> PAPA (Pyogenic arthritis, pyoderma gangrenosum, and acne syndrome) <input type="checkbox"/> PFAPA (Periodic fever, aphthous stomatitis, pharyngitis, adenitis syndrome) <input type="checkbox"/> SAPHO (Synovitis, acne, pustulosis, hyperostosis, osteitis) <input type="checkbox"/> TRAPS (TNF receptor-associated periodic syndrome) <input type="checkbox"/> Unknown origin <input type="checkbox"/> Other
2 Has subject had positive genetic test(s) confirming diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown
3 Has there been disease activity in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Uveitis Disease Specific Form — Baseline	
1 Uveitis type (<i>check only one</i>):	<input type="checkbox"/> Anterior uveitis (includes: iritis, iridocyclitis, anterior cyclitis) <input type="checkbox"/> Intermediate uveitis (includes: pars planitis, posterior cyclitis, hyalitis) <input type="checkbox"/> Posterior uveitis (includes: choroiditis, chorioretinitis, retinochoroiditis, retinitis, neuroretinitis) <input type="checkbox"/> Panuveitis (anterior uveitis, + intermediate and/ or posterior uveitis)
2 Which eye(s) has uveitis affected (<i>check all that apply</i>)?	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Unknown
3 What is the length of the current episode of active uveitis (<i>check only one</i>)?	<input type="checkbox"/> In remission <input type="checkbox"/> < 3 months <input type="checkbox"/> ≥ 3 months <input type="checkbox"/> Unknown
4 Current uncorrected vision:	Right eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown Left eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown
5 Current corrected vision:	Right eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown Left eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown
6 Eye complications to date (<i>check all that apply</i>):	<input type="checkbox"/> None <input type="checkbox"/> Snowbanks <input type="checkbox"/> Increased intraocular pressure <input type="checkbox"/> Snowballs <input type="checkbox"/> Keratic precipitates <input type="checkbox"/> Retinal vasculitis <input type="checkbox"/> Posterior synechia <input type="checkbox"/> Macular atrophy <input type="checkbox"/> Cataract(s) <input type="checkbox"/> Hypopyon <input type="checkbox"/> Macular edema <input type="checkbox"/> Iris nodules <input type="checkbox"/> Epiretinal membrane <input type="checkbox"/> Band keratopathy
7 Has subject ever used topical steroid drops?	<input type="checkbox"/> Yes → If Yes: What was maximum frequency (<i>check one</i>)? <input type="checkbox"/> Hourly <input type="checkbox"/> 2 times per day <input type="checkbox"/> Every 2 hours <input type="checkbox"/> Once per day <input type="checkbox"/> 6 times per day <input type="checkbox"/> Once every other day <input type="checkbox"/> 4 times per day <input type="checkbox"/> Unknown <input type="checkbox"/> 3 times per day <input type="checkbox"/> No <input type="checkbox"/> Unknown
8 Is subject currently using topical steroid drops?	<input type="checkbox"/> Yes → If Yes: What is current frequency (<i>check one</i>)? <input type="checkbox"/> Hourly <input type="checkbox"/> 2 times per day <input type="checkbox"/> Every 2 hours <input type="checkbox"/> Once per day <input type="checkbox"/> 6 times per day <input type="checkbox"/> Once every other day <input type="checkbox"/> 4 times per day <input type="checkbox"/> Unknown <input type="checkbox"/> 3 times per day How long has subject been on this dose? <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> >3-6 months <input type="checkbox"/> >6-12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown
9 Has subject ever used topical mydriatics?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No <input type="checkbox"/> Unknown
10 Has subject ever used topical anti-glaucoma drops?	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No <input type="checkbox"/> Unknown
11 Has subject ever had eye surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown



Subject Status	
1 Subject status at this visit (check only one):	
<input type="checkbox"/> Active (future follow-up expected)	
<input type="checkbox"/> Inactive (follow-up not expected, but subject still participating in registry) →	<input type="checkbox"/> Referred elsewhere for ongoing care <input type="checkbox"/> 2nd opinion visit <input type="checkbox"/> Subject moved to non-CARRA registry pediatric rheumatologist <input type="checkbox"/> Transitioned to adult rheumatology <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other (specify): _____ _____
<input type="checkbox"/> Discontinuation (alive but no longer participating in registry) →	Date of discontinuation: ____/____/____ <small style="margin-left: 100px;">month day year</small> Reason for discontinuation: <input type="checkbox"/> Withdrew consent <input type="checkbox"/> Site decision (specify): _____ _____ <input type="checkbox"/> Other (specify): _____ _____
<input type="checkbox"/> Deceased →	Date of death: ____/____/____ <small style="margin-left: 100px;">month day year</small> Cause of death: _____ _____ Was death related to rheumatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
2 Check if subject/parent was unable to provide at least one contact outside the home: <input type="checkbox"/>	
3 Check if subject received a protocol waiver for enrollment: <input type="checkbox"/>	



Visit date: ____/____/____
 day month year

Subject Data

- 1 Height: _____ . ____ cm OR Not done
- 2 Weight: _____ . ____ kg OR Not done
- 3 Blood pressure: _____ / _____ OR Not done
- 4 Does the subject smoke? Yes No Unknown
- 5 Does anyone else in the subject's household smoke? Yes No Unknown

Insurance Status

Does subject have health insurance?

- Yes
- No
- Unknown

Health Related Quality of Life Score (from Parent/Subject Worksheets)

Score (check only one): Excellent Very good Good Poor Very poor OR Not done

Parent/Subject Assessments (from Parent/Subject Worksheets)

- Overall well-being score: _____ OR Not done
- Pain score (Parent completes if subject <4; Subject completes if >9): _____ OR Not done OR Not applicable at this age
- Faces Pain Scale score (subject 4-9 years old): _____ OR Not applicable at this age OR Not done

CHAQ (from Parent/Subject Worksheet)

CHAQ disability index score: _____ OR Not done

Physician Global Assessment (from Baseline Physician Worksheet)

Score: _____ OR Not done

ACR Functional Class Current (from Baseline Physician Worksheet)

Check only one:

- Class I (completely able to perform usual daily activities)
- Class II (able to perform usual self-care and vocational activities, but limited in avocational activities)
- Class III (able to perform usual self-care activities, but limited in vocational and avocational activities)
- Class IV (limited ability to perform usual self-care, vocational, and avocational activities)
- Not done
- Unknown



Parent/Subject Questionnaires

Date completed: ____/____/____
month day year

Person completing form: Mother Father Subject Other (specify): _____

Parent

1 How do you rate your child's health? Excellent Very good Good Poor Very poor

2 Considering all the ways that your child's rheumatic condition affects your child, rate how your child is doing:

0 1 2 3 4 5 6 7 8 9 10
Very Very
Well Poor

Please circle one number

3 We are also interested in learning whether or not your child has been affected by pain because of his/her rheumatic condition.

How much pain do you think your child had because of his/her rheumatic condition in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Very Severe
Pain Pain

Please circle one number

OR Subject

1 How do you rate your health? Excellent Very good Good Poor Very poor

2 Considering all the ways that your rheumatic condition affects you, rate how you are doing:

0 1 2 3 4 5 6 7 8 9 10
Very Very
Well Poor

Please circle one number

3 We are also interested in learning whether or not you have been affected by pain because of your rheumatic condition.

How much pain have you had because of your rheumatic condition in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Very Severe
Pain Pain

Please circle one number



Childhood Health Assessment Questionnaire (CHAQ)

Instructions

In this section we are interested in learning how your child's illness affects his/her ability to function in daily life. Please feel free to add any comments on the back of this page. In the following questions, please check the one response that best describes your child's usual activities (averaged over an entire day) **OVER THE PAST WEEK**. **ONLY NOTE THOSE DIFFICULTIES OR LIMITATIONS THAT ARE DUE TO ILLNESS**. If most children at your child's age are not expected to do a certain activity, please mark it as "Not Applicable." **For example, if your child has difficulty in doing a certain activity or is unable to do it because he/she is too young but not because he/she is RESTRICTED BY ILLNESS, please mark it as "Not Applicable."**



CHAQ Functional Ability Scoring and Coding

(Adapted from the scanned instructions received from Dr. Nicola Ruperto)

The DAILY FUNCTION section is designed to assess the patient's functional ability over the past week. It is composed of eight categories, each of which has at least two component questions. Parents are also asked to indicate the use of any aids or devices or if the child needs help from another person for any of these activities. The eight categories are: dressing & grooming, arising, eating, walking, hygiene, reach, grip, and activities.

Possible responses for the component questions are:

- Without ANY difficulty = 0
- With SOME difficulty = 1
- With MUCH difficulty = 2
- UNABLE to do = 3

The highest score for any component question determines the score for that category. If a component question is left blank or the response is too ambiguous to assign a score, then the score for the category is determined by the remaining completed question(s). If all component questions are blank/not applicable, then the category is not scored and not used in the calculation of the final disability index.

If the parent's mark is between the response columns, then move it to the closest one. If it's directly between the two, move it to the higher one.

If either devices and/or help from another person is checked for a category, the score=2. This may determine the score unless the score on any other component question=3. For example, the response to "Dress yourself..." is with SOME difficulty (score=1). The parent has checked the use of a device for dressing, thereby increasing the score to 2. The response to "Shampoo your hair" is UNABLE to do (score=3). Therefore, the score for the DRESSING category is 3.

Devices associated with each category:

- DRESSING & GROOMING Devices used for dressing (button hook, zipper pull, long handles shoe horn, etc.)
- ARISING Built up or special chair
- EATING Built up pencil or special utensils
- WALKING Cane, walker, crutches, wheelchair
- HYGIENE Raised toilet set, bathtub seat, bathtub bar, long-handled appliances in bathroom
- REACH Long-handled appliances for reach
- GRIP Jar opener (for jars previously opened)

Devices written in the "Other" sections are considered only if they would be used for any of the stated categories.

Disability Index Calculation

The index is calculated by adding the scores for each of the categories and dividing by the number of categories answered. If questions in each category were answered, divide by 8. This gives a score in the 0 to 3.0 range.

Scoring worksheet:

- | | |
|---------------------------------|----------------------|
| 1. Dressing and Grooming: _____ | 5. Hygiene: _____ |
| 2. Arising: _____ | 6. Reach: _____ |
| 3. Eating: _____ | 7. Grip: _____ |
| 4. Walking: _____ | 8. Activities: _____ |

Add scores from 1-8 above to get TOTAL: _____

Divide above TOTAL by number of answered categories to get Disability Index (0.00-3.00):

____ . ____ ____

Enter value in the above box for CHAQ score



Childhood Health Assessment Questionnaire (CHAQ)					
Date completed: ____/____/____ <small>month day year</small>					
Person completing form: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Subject <input type="checkbox"/> Other (specify): _____					
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do	Not Applicable
Dressing and Grooming: Is your child able to...					
Dress, including tying shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo his/her hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove socks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cut fingernails?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arising: Is your child able to...					
Stand up from a low chair or floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed or stand up in a crib?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating: Is your child able to...					
Cut his/her own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift up a cup or glass to mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new cereal box?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking: Is your child able to...					
Walk outdoors on flat ground?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Please check any AIDS or DEVICES that your child usually uses for any of the above activities:					
Cane	<input type="checkbox"/>	Devices used for dressing (<i>button hook, zipper pull, long-handled shoe horn, etc.</i>)			<input type="checkbox"/>
Walker	<input type="checkbox"/>	Built up pencil or special utensils			<input type="checkbox"/>
Crutches	<input type="checkbox"/>	Special or built up chair			<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	Other (specify): _____			<input type="checkbox"/>
Please check any categories for which your child usually needs help from another person BECAUSE OF ILLNESS:					
Dressing and grooming	<input type="checkbox"/>	Eating			<input type="checkbox"/>
Arising	<input type="checkbox"/>	Walking			<input type="checkbox"/>

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Childhood Health Assessment Questionnaire (CHAQ)					
	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do	Not Applicable
Hygiene: Is your child able to...					
Wash and dry entire body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a tub bath (get in and out of tub)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet or potty chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comb/brush hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach: Is your child able to...					
Reach and get down a heavy object such as a large game or books from just above his/her head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing or a piece of paper from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull on a sweater over his/her head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn neck to look back over shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grip: Is your child able to...					
Write or scribble with pen or pencil?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open jars that have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push open a door when he/she has to turn a door knob?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities: Is your child able to...					
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 or toy car or school bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ride bike or tricycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do household chores (e.g., wash dishes, take out trash, vacuuming, yard work, make bed, clean room)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run and play?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please check any AIDS or DEVICES that your child usually uses for any of the above activities:					
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	<input type="checkbox"/>		
Please check any categories for which your child usually needs help from another person BECAUSE OF ILLNESS:					
Hygiene	<input type="checkbox"/>	Gripping and opening things	<input type="checkbox"/>		
Reach	<input type="checkbox"/>	Errand and chores	<input type="checkbox"/>		



Follow-Up Physician Worksheet

Date completed: ____/____/____
month day year

Rheumatologic Disease Diagnosis

What is the subject's rheumatologic disease diagnosis? (If multiple, please select those that meet disease classification criteria.)

- Mixed connective tissue disease
- Systemic lupus erythematosus
- Primary Sjögren's disease
- Systemic sclerosis
- Juvenile dermatomyositis
- Localized Scleroderma
- Juvenile idiopathic arthritis/Juvenile ankylosing spondylitis
- Chronic vasculitis (excluding Kawasaki and Henoch-Schönlein purpura)
- Sarcoid
- Auto-inflammatory disease (including fever syndromes, chronic recurrent multifocal osteomyelitis)
- Idiopathic uveitis (not associated with other rheumatologic disease)
- Juvenile primary fibromyalgia

Physician Global Assessment of Disease Activity

Instructions: Indicate the assessed level of this subject's disease activity. (To be filled out the **same day** as subject's visit. Do not wait for laboratory results.)

At this time, the overall disease activity is:

Not Active												Very Active
0	1	2	3	4	5	6	7	8	9	10		

Please circle one number

ACR Functional Class

ACR functional class current (check only one):

- Class I (completely able to perform usual daily activities)
- Class II (able to perform usual self-care and vocational activities, but limited in avocational activities)
- Class III (able to perform usual self-care activities, but limited in vocational and avocational activities)
- Class IV (limited ability to perform usual self-care, vocational, and avocational activities)
- Not done
- Unknown

Disease Update**1 What is the subject's primary rheumatologic disease diagnosis?** (If multiple, please select those that meet disease classification criteria.)

- Mixed connective tissue disease
- Systemic lupus erythematosus
- Primary Sjögren's disease
- Systemic sclerosis
- Juvenile dermatomyositis
- Localized scleroderma
- Juvenile idiopathic arthritis/ Juvenile ankylosing spondylitis
- Chronic vasculitis (excluding Kawasaki and Henoch-Schönlein purpura)
- Sarcoid
- Auto-inflammatory (including fever syndrome, Chronic recurrent multifocal osteomyelitis)
- Idiopathic uveitis (not associated with other rheumatologic disease)
- Juvenile primary fibromyalgia

2 Has the subject been hospitalized since the last study visit?

- Yes → **If Yes: Was this due to** (check all that apply):
 - Flare of rheumatic disease
 - Complication of disease
 - Medication side effect
 - Infection
 - Malignancy
 - Trauma/injury
 - Other, specify: _____
 - Unknown
- No
- Unknown

3 Has the subject had any newly diagnosed or acquired conditions since the last study visit?

- Yes → **If Yes: Check all that apply:**
 - Autism spectrum disorder
 - Auto-immune hepatitis
 - Auto-immune thyroid disease
 - Celiac disease
 - Cerebral palsy
 - Chronic asthma
 - Congenital heart disease
 - Cystic fibrosis
 - Demyelinating disease
 - Diabetes – Type 1
 - Diabetes – Type 2
 - Malignancy
 - Primary immunodeficiency syndrome(s)
 - Seizure disorder
 - Other autoimmune disease (specify): _____
 - Other major congenital or acquired disease/condition (specify): _____
- No
- Unknown



Medications Since Last Visit

Please indicate all sources of information used to answer medication items below:

- Family or subject recall Limited chart review Provider recall Complete chart review Other

Has the subject been in any blinded drug trial(s) where treatment assigned has not yet been revealed to physician or subject not yet transitioned to open-label phase?

- Yes → Check all that apply:
 Current study → Specify drug(s): _____
 Post study → Specify drug(s): _____
 No
 Unknown

1 Since the last study visit, has the subject taken any non-biologic immune modulators and disease-modifying antirheumatic drugs (DMARDs):

- No
 Yes → If Yes: Check one answer per medication:

Azathioprine (<i>Imuran</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cyclophosphamide oral (<i>Cytoxan</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cyclophosphamide pulse (<i>Cytoxan</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cyclosporine A (<i>Neoral, Sandimmune, Gengraf</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hydroxychloroquine (<i>Plaquenil</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Leflunomide (<i>Arava</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Methotrexate—oral	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Methotrexate—subcutaneous	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Mycophenylate mofetil (<i>CellCept, Myfortic</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sulfasalazine (<i>Azulfidine</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tacrolimus (<i>Prograf</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Lenalidomide (<i>Revlimid</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Thalidomide (<i>Thalomid</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Colchicine (<i>Colcris</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Do not include drugs newly prescribed at this visit.

Medications Since Last Visit (continued)

2 Since the last study visit, has subject taken any Biologics?
 No Yes → If Yes: Check one answer per medication:

Abatacept (<i>Orencia</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Adalimumab (<i>Humira</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Anakinra (<i>Kineret</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Belimumab (<i>Benlysta</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Canakinumab (<i>Ilaris</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Certolizumab (<i>Cimzia</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Epratuzumab (<i>LymphoCide</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Etanercept (<i>Enbrel</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Golimumab (<i>Simponi</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Infliximab (<i>Remicade</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
IVIG	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rilonacept (<i>Arcalyst</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rituximab (<i>Rituxan</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tocilizumab (<i>Actemra</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other biologic (<i>specify</i>):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Other biologic (<i>specify</i>):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

3 Since the last study visit has the subject taken any Glucocorticoids (other than inhaled and intranasal):
 No Yes → If Yes: Check one answer per medication:

Intraarticular corticosteroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
IV pulse steroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Systemic corticosteroids long term daily	<input type="checkbox"/> Yes →	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes: What is cumulative exposure? <input type="checkbox"/> < 1 month <input type="checkbox"/> ≥ 1 month <input type="checkbox"/> Unknown			
Intraocular injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Steroid eye drops	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

4 Since the last study visit has the subject taken any of these other drugs of interest?
 No Yes → If Yes: Check one answer per medication:

Daily nonsteroidal anti-inflammatory drugs (<i>NSAIDs</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Selective serotonin reuptake inhibitors (<i>SSRIs</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Tri-cyclic antidepressants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Serotonin norepinephrine reuptake inhibitors (<i>SNRIs</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Gamma-aminobutyric acid (<i>GABA</i>) analogues	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Opioids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cimetidine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Herbals or non-vitamin supplements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Do not include drugs newly prescribed at this visit.

Juvenile Idiopathic Arthritis/ Juvenile Ankylosing Spondylitis Disease Specific Form
Follow-up

1 Physician assigned category (check only one):

<input type="checkbox"/> Systemic JIA	<input type="checkbox"/> Psoriatic
<input type="checkbox"/> Polyarticular RF (-)	<input type="checkbox"/> ERA
<input type="checkbox"/> Polyarticular RF (+)	<input type="checkbox"/> Undifferentiated
<input type="checkbox"/> Oligoarticular persistent	<input type="checkbox"/> Juvenile Ankylosing Spondylitis (JAS)
<input type="checkbox"/> Oligoarticular extended	<input type="checkbox"/> Other

2 Total number of joints affected with arthritis since last study visit: None 1-4 joints ≥ 5 joints

3 Total number of currently active joints: _____

4 Has subject had any of the following disease manifestations since the last study visit:

Quotidian fever attributable to JIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Evanescant rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Generalized lymphadenopathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hepatomegaly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Splenomegaly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Serositis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nail pitting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Dactylitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Leg length discrepancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Enthesitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sacroiliac joint tenderness and/or inflammatory lumbosacral pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Limited lumbosacral mobility (modified Schober test)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Inflammatory bowel disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Uveitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<i>If Current, complete Follow-Up Uveitis form</i>			
Pulmonary hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Rheumatoid nodules	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Interstitial lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

5 Has the subject had any of the following positive diagnostic tests since the last study visit:

Positive Anti-CCP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown
Positive IgM RF	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown
Positive HLAB27	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not done	<input type="checkbox"/> Unknown

6 Has the subject had any joint imaging done since the last study visit?

Yes → if Yes: Indicate findings (check all that apply):

<input type="checkbox"/> Normal	<input type="checkbox"/> Ankylosis
<input type="checkbox"/> Joint space narrowing	<input type="checkbox"/> Sacroiliac involvement
<input type="checkbox"/> Erosion	<input type="checkbox"/> Other

No
 Unknown

7 Parent/subject assessment of disease activity (from worksheet): _____ OR Not done



RHEUMATOLOGIC JOINT ASSESSMENT (page 1 of 2)

Date of visit (dd/mmm/yyyy): ____/____/____	Visit: ____
---	-------------

RIGHT SIDE				UPPER	LEFT SIDE			
Swelling	POM	Tend	LOM	Joint	Swelling	POM	Tend	LOM
				Temp. Mand.				
			N/A	Sterno.clav				N/A
			N/A	Acro. Clav.				N/A
				Shoulder				
				Elbow				
				Wrist				
				MCP I				
				MCP II				
				MCP III				
				MCP IV				
				MCP V				
				PIP I				
				PIP II				
				PIP III				
				PIP IV				
				PIP V				
				DIP II				
				DIP III				
				DIP IV				
				DIP V				

RHEUMATOLOGIC JOINT ASSESSMENT (page 2 of 2)

Date of visit (dd/mmm/yyyy): ____/____/____

RIGHT SIDE				LOWER	LEFT SIDE			
Swelling	POM	Tend	LOM	Joint	Swelling	POM	Tend	LOM
N/A				Hip	N/A			
				Knee				
				Ankle				
N/A				Subtalar	N/A			
				Tarsi				
				MTP I				
				MTP II				
				MTP III				
				MTP IV				
				MTP V				
				Toes (PIP) I				
				Toes (PIP) II				
				Toes (PIP) III				
				Toes (PIP) IV				
				Toes (PIP) V				
NA			N/A	Sacroiliac	N/A			N/A
				Cervical spine	N/A			
				Thoracic spine	N/A			
				Lumbar spine	N/A			

_____ (to be signed by assessor)

Juvenile Dermatomyositis Disease Specific Form — Follow-up	
1	JDM category (check one): <input type="checkbox"/> Definite <input type="checkbox"/> Probable <input type="checkbox"/> Amyopathic
2	Childhood Myositis Assessment Scale (CMAS) score (0–52): ____ OR <input type="checkbox"/> Not done
3	Manual muscle test (MMT-8) score (0–80): ____ OR <input type="checkbox"/> Not done
4	Does the subject have any of the following disease manifestations at today's study visit (please answer all questions):
Symmetric proximal muscle weakness	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Not done
Gottren's sign, papules or heliotrope	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Malar or facial erythema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
V or shawl sign	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Lipodystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Periungual telangiectasia (nailfold capillary changes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Contractures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
5	Has the subject had documented evidence of the following since the last study visit:
Calcinosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Small joint arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Large joint arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dysphagia or dysphonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle enzyme elevation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac involvement	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Decreased cardiac output <input type="checkbox"/> Myocarditis <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Interstitial lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
GI ulceration due to JDM	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6	Has the subject had any of the following diagnostic assessments since the last study visit:
Pulmonary function testing (PFTs)	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased FVC <input type="checkbox"/> Decreased DLCO <input type="checkbox"/> Reversible airway disease <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
MRI consistent with inflammatory muscle disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
EMG consistent with inflammatory myopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Muscle biopsy consistent with inflammatory muscle disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown



CHILDHOOD MYOSITIS ASSESSMENT SCALE (CMAS) SCORING SHEET

1. **HEAD LIFT:**
 0 = Unable 3 = 30-59
 1 = 1-9 sec 4 = 60-119 sec
 2 = 10-29 5 = ≥ 2 min
 Score _____
2. **LEG RAISE/TOUCH OBJECT:**
 0 = Unable to lift leg off table.
 1 = Able to clear table, but cannot touch object (examiner's hand).
 2 = Able to lift leg high enough to touch object (examiner's hand).
 Score _____
3. **STRAIGHT LEG LIFT/DURATION:**
 0 = Unable 3 = 30-59 sec
 1 = 1-9 sec 4 = 60-119 sec
 2 = 10-29 sec 5 = ≥ 2 min
 Score _____
4. **SUPINE TO PRONE:**
 0 = Unable. Has difficulty even turning onto side; able to pull right arm under torso only slightly or not at all.
 1 = Turns onto side fairly easily, but cannot fully free right arm and is unable to fully assume a prone position.
 2 = Easily turns onto side; has some difficulty freeing arm, but fully frees arm and fully assumes a prone position.
 3 = Easily turns over, fully frees right arm with no difficulty.
 Score _____
5. **SITS-UPS:**
 Hands on thighs, with counterbalance _____
 Hands across chest, with counterbalance _____
 Hands behind head, with counterbalance _____
 Hands on thighs, without counterbalance _____
 Hands across chest, without counterbalance _____
 Hands behind head, without counterbalance _____
 Score (0-6) _____
6. **SUPINE TO SIT:**
 0 = Unable by self.
 1 = Much difficulty. Very slow, struggles greatly, barely makes it.
 Almost unable.
 2 = Some difficulty. Able, but is somewhat slow, struggles some.
 3 = No difficulty.
 Score _____
7. **ARM RAISE/STRAIGHTEN:**
 0 = Cannot raise wrists up to the level of the A-C joint.
 1 = Can raise wrists at least up to the level of the A-C joint, but not above top of head.
 2 = Can raise wrists above top of head, but cannot raise arms straight above head so that elbows are in full extension.
 3 = Can raise arms straight above head so that elbows are in full extension.
 Score _____
8. **ARM RAISE/DURATION:** Can maintain wrists above top of head for:
 0 = Unable 3 = 30-59 sec
 1 = 1-9 sec 4 = ≥ 60 sec
 2 = 10-29 sec
 Score _____
9. **FLOOR SIT:** Going from a standing position to a sitting position on the floor:
 0 = Unable. Afraid to even try, even if allowed to use a chair for support. Child fears that he/she will collapse, fall into a sit, or harm self.
 1 = Much difficulty. Able, but needs to hold onto a chair for support during descent. Unable, or unwilling to try if not allowed to use a chair for support.
 2 = Some difficulty. Can go from stand to sit without using a chair for support, but has at least some difficulty during descent. May need Gower's. Descends somewhat slowly and/or apprehensively; may not have full control or balance as maneuvers into a sit.
 3 = No difficulty. Requires no compensatory maneuvering.
 Score _____
10. **ALL FOURS MANEUVER:**
 0 = Unable to go from a prone to an all-fours position.
 1 = Barely able to assume and maintain an all-fours position. Unable to raise head to look straight ahead.
 2 = Can maintain all-fours position with back straight and head raised (so as to look straight ahead). But, cannot creep (crawl) forward.
 3 = Can maintain all-fours, look straight ahead and creep (crawl) forward.
 4 = Maintains balance while lifting and extending one leg.
 Score _____
11. **FLOOR RISE:** Going from a kneeling position on the floor to a standing position:
 0 = Unable, even if allowed to use a chair for support.
 1 = Much difficulty. Able, but needs to use a chair for support. (Unable if not allowed to use a chair.)
 2 = Moderate difficulty. Able to get up without using a chair for support, but needs to place one or both hands on thighs/knees or floor. (Unable without using hands.)
 3 = Mild difficulty. Does not need to place hands on knees, thighs or floor, but has at least some difficulty during ascent.
 4 = No difficulty.
 Score _____
12. **CHAIR RISE:**
 0 = Unable to rise up from chair, even if allowed to place hands on sides of chair seat.
 1 = Much difficulty. Able, but needs to place hands on sides of seat. Unable if not allowed to place hands on sides of seat.
 2 = Moderate difficulty. Able, but needs to place hands on knees/thighs. Does not need to place hands on sides of seat.
 3 = Mild difficulty. Does not need to place hands on seat, knees or thighs but has at least some difficulty during ascent.
 4 = No difficulty.
 Score _____
13. **STOOL STEP:**
 0 = Unable.
 1 = Much difficulty. Able, but needs to place one hand on exam table (or examiner's hand).
 2 = Some difficulty. Able, does not need to use exam table for support, but needs to use hand on knee/thigh.
 3 = Able. Does not need to use exam table or hand on knee/thigh.
 Score _____
14. **PICK-UP:**
 0 = Unable to bend over and pick up pencil off floor.
 1 = Much difficulty. Able, but relies heavily on support gained by placing hands on knees/thighs.
 2 = Some difficulty. Has some difficulty (but not "much-difficulty"). Needs to at least minimally and briefly place hand(s) on knees/thighs for support. Is somewhat slow.
 3 = No difficulty. No compensatory maneuver necessary.
 Score _____

TOTAL CMAS SCORE: _____

The maximum possible total score for the 14 maneuvers is 52

Systemic Sclerosis Disease Specific Form — Follow-up

1 Is disease manifestation present at today's study visit? Please answer all questions.	
Skin changes	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Sclerodactyly <input type="checkbox"/> Calcinosis <input type="checkbox"/> Proximal to MCPs <input type="checkbox"/> Proximal to elbow <input type="checkbox"/> Telangiectasia <input type="checkbox"/> Other <input type="checkbox"/> No
Nail-bed capillary abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digital ulceration/gangrene	<input type="checkbox"/> Yes <input type="checkbox"/> No
Raynaud's	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Contractures <input type="checkbox"/> Myositis <input type="checkbox"/> Tendinopathy <input type="checkbox"/> Other <input type="checkbox"/> Arthritis <input type="checkbox"/> No
2 Has the subject had any of the following disease manifestations since the last study visit?	
Pulmonary involvement: Were any studies done?	<input type="checkbox"/> Yes → If Yes: Check all abnormalities noted: <input type="checkbox"/> None <input type="checkbox"/> Dyspnea <input type="checkbox"/> Decreased DLCO/hypoxemia <input type="checkbox"/> Parenchymal pulmonary disease <input type="checkbox"/> Restrictive lung disease <input type="checkbox"/> Radiologic or pathologic evidence of fibrosis <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Other <input type="checkbox"/> No
Cardiac disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Pericardial effusion <input type="checkbox"/> Angina <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Other <input type="checkbox"/> Myocardiopathy <input type="checkbox"/> No
Renal disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Abnormal urinary sediment <input type="checkbox"/> Renovascular hypertension <input type="checkbox"/> Elevated creatinine <input type="checkbox"/> Imaging abnormality <input type="checkbox"/> Fibrosis on biopsy <input type="checkbox"/> Other <input type="checkbox"/> No
GI disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Dysphagia <input type="checkbox"/> Documented GERD <input type="checkbox"/> GI dysmotility <input type="checkbox"/> Esophagitis <input type="checkbox"/> Stricture <input type="checkbox"/> Malabsorption <input type="checkbox"/> Other <input type="checkbox"/> No

Localized Scleroderma Disease Specific Form — Follow-up	
1 Localized scleroderma subtype (check all that apply): <input type="checkbox"/> Circumscribed morphea → Check all that apply: <input type="checkbox"/> Superficial <input type="checkbox"/> Deep <input type="checkbox"/> Linear scleroderma → Check all that apply: <input type="checkbox"/> Linear involving trunk/limbs <input type="checkbox"/> Linear involving face/scalp (En coup de saber, Parry-Romberg) <input type="checkbox"/> Generalized morphea <input type="checkbox"/> Pansclerotic morphea <input type="checkbox"/> Eosinophilic fasciitis <input type="checkbox"/> Other	
2 Location of lesions (check all that apply):	<input type="checkbox"/> Scalp <input type="checkbox"/> Chest <input type="checkbox"/> Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Face <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Buttock <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Abdomen <input type="checkbox"/> Other, specify: _____
3 Does the subject have any of the following disease manifestations on today's study visit or documented since the last study visit? Please answer all questions.	
New lesion(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Extension of previous lesion(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Erythematous/violaceous lesion color	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lesion warmth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin Induration perimeter lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin Thickening center of lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dermal atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subcutaneous atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hyperpigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hypopigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hair loss associated with lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Muscle atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Extremity shortening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Joint contracture	<input type="checkbox"/> Yes → If Yes: Specify number of joints affected: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> > 5 <input type="checkbox"/> None <input type="checkbox"/> Unknown
Hemifacial atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4 Does the subject have any extracutaneous manifestations on today's study visit or documented since the last study visit?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Arthritis <input type="checkbox"/> GI involvement <input type="checkbox"/> Neurological involvement <input type="checkbox"/> Eye involvement <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
5 Has the subject had any laboratory findings or imaging abnormalities since the last study visit? Please answer all questions below.	
Abnormal CK	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Abnormal aldolase	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Presence of eosinophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Elevated IgG	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
CNS imaging abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
GI study abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

Juvenile Primary Fibromyalgia Syndrome Disease Specific Form — Follow-up

1 Has this subject had any of the following symptoms within the last month (please answer all questions)?	
Widespread pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Disordered sleep?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Non-restorative <input type="checkbox"/> Increased sleep latency <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Frequent wakings <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> No, on medication <input type="checkbox"/> Unknown
Frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Irritable bowel syndrome (IBS) symptoms with prior physician diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Subjective soft tissue swelling of the extremities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Numbness and tingling of the extremities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by weather?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain modulated by stress/anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2 Has subject participated in organized physical activity since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes, but curtailed due to pain <input type="checkbox"/> No <input type="checkbox"/> Unknown
3 Has subject been diagnosed with depression and/or anxiety disorder since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4 What treatments have been recommended/prescribed/provided by a pediatric rheumatologist to the subject since the last study visit (check all that apply)?	
<input type="checkbox"/> Education regarding fibromyalgia and chronic pain	<input type="checkbox"/> Referral for psychotropic medications
<input type="checkbox"/> Sleep hygiene	<input type="checkbox"/> Pain clinic → Choose type of pain clinic: <input type="checkbox"/> Pediatric pain clinic <input type="checkbox"/> Adult pain clinic
<input type="checkbox"/> Graduated aerobic exercise program	
<input type="checkbox"/> Physical therapy for stretching and strengthening	
<input type="checkbox"/> General counseling	<input type="checkbox"/> Integrative medicine clinic referral
<input type="checkbox"/> Cognitive behavioral therapy	<input type="checkbox"/> Rehabilitation clinic referral
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Other
<input type="checkbox"/> Medications	<input type="checkbox"/> None

Juvenile Primary Fibromyalgia Syndrome Disease Specific Form — Follow-up (continued)

<p>5 Did subject pursue these recommendations since the last study visit?</p>	<p><input type="checkbox"/> None of recommendations were pursued → If None: In dicate reason (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Services not available <input type="checkbox"/> Insurance would not cover services <input type="checkbox"/> Subject/family not interested <input type="checkbox"/> Other <p><input type="checkbox"/> Only some recommendations were pursued → If Only some: In dicate reason (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Services not available <input type="checkbox"/> Insurance would not cover services <input type="checkbox"/> Subject/family not interested <input type="checkbox"/> Other <p><input type="checkbox"/> Most or all recommendations were pursued <input type="checkbox"/> Recommendations made today <input type="checkbox"/> Unknown</p>
<p>6 Has subject used other therapies since the last study visit?</p>	<p><input type="checkbox"/> Yes → If Yes: Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture/acupressure <input type="checkbox"/> Craniosacral therapy <input type="checkbox"/> Mindfulness/meditation <input type="checkbox"/> Therapeutic massage <input type="checkbox"/> Physical therapy <input type="checkbox"/> Dietary supplements/herbal remedies <input type="checkbox"/> Hypnosis <input type="checkbox"/> Yoga <input type="checkbox"/> Chiropractor <input type="checkbox"/> Other <p><input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

SLE / MCTD / Sjögren's Disease Specific Form — Follow-up	
1 Disease manifestation present? (Please answer all questions.)	
Seizure*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Psychosis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Organic Brain Syndrome*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Visual Disturbance*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cranial Nerve Disorder*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other neurological manifestation (other than seizure, psychosis, organic brain syndrome, visual disturbance or cranial nerve disorder)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lupus headache*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cerebral vascular accident*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Myositis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sclerodactyly or swollen hands	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Raynaud's	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Esophageal dysmotility	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown

SLE / MCTD / Sjögren's Disease Specific Form — Follow-up (continued)	
Vasculitis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Rash*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Alopecia*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Mucosal ulcers*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
SICCA syndrome	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Fever > 38° C*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pleurisy*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pericarditis*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Myocarditis	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pulmonary involvement	<input type="checkbox"/> Yes, in the last 10 days → If Yes: Check all that apply: <input type="checkbox"/> Decreased adjusted DLCO (diffusion capacity) <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Pneumonitis <input type="checkbox"/> Other <input type="checkbox"/> Lung biopsy performed <input type="checkbox"/> Yes, in the last 11 days thru last study visit → If Yes: Check all that apply: <input type="checkbox"/> Decreased adjusted DLCO (diffusion capacity) <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Pneumonitis <input type="checkbox"/> Other <input type="checkbox"/> Lung biopsy performed <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dialysis	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> Yes, in the last 11 days thru last study visit <input type="checkbox"/> No <input type="checkbox"/> Unknown

* Questions are from SLEDAI; EDC will calculate and display the total score.

SLE / MCTD / Sjögren's Disease Specific Form — Follow-up (continued)

2	Has subject had an arterial thrombotic event since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3	Has subject had a venous thrombotic event since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4	Has subject been diagnosed with coronary heart disease since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5	Has subject had imaging evidence of avascular necrosis of any joint since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
6	Has subject had a renal transplant since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
7	Has subject been diagnosed with renal disease since the last study visit?	<input type="checkbox"/> Yes If Yes: Check all that apply: <input type="checkbox"/> Glomerulonephritis <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Interstitial nephritis <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown

Biopsies

8	Has the subject had any non-renal biopsies consistent with disease diagnosis since the last study visit?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Skin <input type="checkbox"/> Lacrimal gland <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
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9 Has subject had one or more renal biopsies since last study visit? Yes → **If Yes: Answer questions below** No

Biopsy Date: MMM/YYYY	WHO Class (I–VI) <i>Check all that apply</i>	And/OR ISN/RPS Class (I–VI) <i>Check all that apply</i>
____/____/____ <i>month year</i> OR record UNK for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
____/____/____ <i>month year</i> OR record UNK for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done
____/____/____ <i>month year</i> OR record UNK for portion of date unknown	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III → Check one: <input type="checkbox"/> Active <input type="checkbox"/> Active/chronic <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown <input type="checkbox"/> IV → Check one: <input type="checkbox"/> Segmented (active) <input type="checkbox"/> Global (active) <input type="checkbox"/> Segmented (active/chronic) <input type="checkbox"/> Segmented (chronic) <input type="checkbox"/> Global (chronic) <input type="checkbox"/> Unknown <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/> Unknown <input type="checkbox"/> Not done

SLE / MCTD / Sjögren's Disease Specific Form — Follow-up (continued)

10 Serologies (Please answer all questions.)	
Positive Anti-Smith (Sm) antibodies since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-RNP antibodies since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-Ro antibodies since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive Anti-La antibodies since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive anti-phospholipid antibodies (including anti-cardiolipin antibodies), anti-β2 glycoprotein 1 antibodies or positive lupus anticoagulant since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Anti-double stranded DNA antibodies in the past 10 days?*	<input type="checkbox"/> Yes → If Yes: Was the test positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Has test been performed since the last study visit? <input type="checkbox"/> Yes → If Yes: Was the test positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown
Complement levels (C3, C4, CH50) in the past 10 days?*	<input type="checkbox"/> Yes → If Yes: Are any of the levels below the lower limits of normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Have these tests been performed since the last study visit? <input type="checkbox"/> Yes → If Yes: Were any of the levels below the lower limits of normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown
11 Cytopenias (Please answer all questions.)	
Anemia hemoglobin (< 11 g/dL)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Leukopenia (< 3000 white blood cells/mm ³ *)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Thrombocytopenia (< 100K platelets/mm ³ *)	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

SLE / MCTD / Sjögren's Disease Specific Form rm — Follow-up (continued)
12 Urinalysis and renal function tests (Please answer all questions.)

Urinary casts*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Hematuria (> 5 red cells)*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Pyuria (> 5 white cells)*	<input type="checkbox"/> Yes, in the last 10 days <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Proteinuria (> 0.5 protein/creatinine ratio or > 500 mg protein/24 h) in last 10 days?*	<input type="checkbox"/> Yes → If Yes: Is this a new onset or increase of > 0.5 protein/creatinine ratio or > 500 mg protein/24h? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No → If No: Has proteinuria (> 0.5 protein/creatinine ratio pr > 500 mg protein/24h) been present since the last study visit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Sample from the first void of the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Serum creatinine (most recent)	_____ mg/dL OR <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

* Questions are from SLEDAI; EDC will calculate and display the total score.

Sarcoid Disease Specific Form — Follow-up
1 Is disease manifestation present at today's study visit? Please answer all questions.

Lymphadenopathy	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Abdominal/pelvic <input type="checkbox"/> Mediastinal <input type="checkbox"/> Peripheral <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin lesions	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Livedo reticularis <input type="checkbox"/> Macules <input type="checkbox"/> Papules <input type="checkbox"/> Nodules <input type="checkbox"/> Ulcers <input type="checkbox"/> Erythema nodosum <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hepato- or splenomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

2 Has subject had any of the following disease manifestations since the last study visit?

Pulmonary disease	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Pleural disease <input type="checkbox"/> Parenchymal pulmonary disease <input type="checkbox"/> Restrictive lung disease <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hepatic involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Uveitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Bone lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Neurologic involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

3 Results of diagnostic tests done at today's study visit or within the last month:

Hypercalcuria or hypercalcemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Elevated ACE	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

4 Has the subject had a biopsy with histology consistent with sarcoid since the last study visit?

	<input type="checkbox"/> Yes → If Yes: Check all that apply: <input type="checkbox"/> Bone <input type="checkbox"/> Lymph node <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Parotid <input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Kidney <input type="checkbox"/> Synovium <input type="checkbox"/> Liver <input type="checkbox"/> Other <input type="checkbox"/> Biopsies performed, but not consistent with sarcoid <input type="checkbox"/> No biopsies performed <input type="checkbox"/> Unknown
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Vasculitis Disease Specific Form — Follow-up	
1 Vasculitis diagnosis (check only one):	<input type="checkbox"/> Childhood Wegener's Granulomatosis <input type="checkbox"/> Childhood Systemic Polyarteritis Nodosa <input type="checkbox"/> Childhood Takayasu's Arteritis <input type="checkbox"/> Microscopic Polyangitis <input type="checkbox"/> Primary Central Nervous System Vasculitis <input type="checkbox"/> Cutaneous Polyarteritis Nodosa <input type="checkbox"/> Behcet's Syndrome <input type="checkbox"/> Churg-Strauss Syndrome
2 Has subject had any of the following disease manifestations since the last study visit? Please answer all questions.	
Hypertension (or on chronic antihypertensive medications)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Skin lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Mucosal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Eye involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Upper respiratory tract involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lower respiratory tract involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Renal insufficiency	<input type="checkbox"/> Yes → If Yes: Check treatment <input type="checkbox"/> On dialysis <input type="checkbox"/> Not on dialysis <input type="checkbox"/> Received renal transplant <input type="checkbox"/> Other <input type="checkbox"/> No <input type="checkbox"/> Unknown
Liver involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Intestinal involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiovascular involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Central nervous system involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Peripheral nervous system involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Positive c-ANCA or anti-PR3	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown
Positive p-ANCA or anti-MPO	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

Autoinflammatory Disease Specific Form — Follow-up	
1 Current diagnosis (check all that apply):	<input type="checkbox"/> CH (Cyclic hematopoiesis) <input type="checkbox"/> CINCA (Chronic infantile neurological cutaneous and articular syndrome) / NOMID (Neonatal-onset multisystem inflammatory disease) <input type="checkbox"/> CRMO (Chronic recurrent multifocal osteomyelitis) <input type="checkbox"/> DIRA (Deficiency of interleukin-1 receptor antagonist) <input type="checkbox"/> FCAS(Familial cold autoinflammatory syndrome) <input type="checkbox"/> FMF (Familial Mediterranean fever) <input type="checkbox"/> HIDS (Hyperimmunoglobulin (Ig) D syndrome) <input type="checkbox"/> Majeed syndrome <input type="checkbox"/> MWS (Muckle-Wells syndrome) <input type="checkbox"/> PAPA (Pyogenic arthritis, pyoderma gangrenosum, and acne syndrome) <input type="checkbox"/> PFAPA (Periodic fever, aphthous stomatitis, pharyngitis, adenitis syndrome) <input type="checkbox"/> SAPHO (Synovitis, acne, pustulosis, hyperostosis, osteitis) <input type="checkbox"/> TRAPS (TNF receptor-associated periodic syndrome) <input type="checkbox"/> Unknown origin <input type="checkbox"/> Other
2 Has subject had positive genetic test(s) confirming diagnosis since last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown
3 Has there been disease activity in the last six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Uveitis Disease Specific Form — Follow-Up	
1 Uveitis type (check only one):	<input type="checkbox"/> Anterior uveitis (includes: iritis, iridocyclitis, anterior cyclitis) <input type="checkbox"/> Intermediate uveitis (includes: pars planitis, posterior cyclitis, hyalitis) <input type="checkbox"/> Posterior uveitis (includes: choroiditis, chorioretinitis, retinochoroiditis, retinitis, neuroretinitis) <input type="checkbox"/> Panuveitis (anterior uveitis, + intermediate and/ or posterior uveitis)
2 Since the last study visit, has the uveitis changed in terms of involvement of additional eye?	<input type="checkbox"/> Yes → If Yes: Which eye(s) ever involved (check all that apply)? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Unknown <input type="checkbox"/> No
3 What is the length of the current episode of active uveitis (check only one)?	<input type="checkbox"/> In remission <input type="checkbox"/> < 3 months <input type="checkbox"/> ≥ 3 months <input type="checkbox"/> Unknown
4 Current uncorrected vision:	Right eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown Left eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown
5 Current corrected vision:	Right eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown Left eye: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Blind <input type="checkbox"/> Unknown
6 Since the last study visit, have there been any new eye complications?	<input type="checkbox"/> Yes → If Yes: Check all that apply: <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Increased intraocular pressure <input type="checkbox"/> Keratic precipitates <input type="checkbox"/> Posterior synechia <input type="checkbox"/> Cataract(s) <input type="checkbox"/> Macular edema <input type="checkbox"/> Epiretinal membrane <input type="checkbox"/> Snowbanks </div> <div style="width: 35%;"> <input type="checkbox"/> Snowballs <input type="checkbox"/> Retinal vasculitis <input type="checkbox"/> Macular atrophy <input type="checkbox"/> Hypopyon <input type="checkbox"/> Iris nodules <input type="checkbox"/> Band keratopathy </div> </div> <input type="checkbox"/> No <input type="checkbox"/> Unknown
6 Has subject used topical steroid drops since the last study visit?	<input type="checkbox"/> Yes → If Yes: What was maximum frequency since last study visit? <input type="checkbox"/> Hourly <input type="checkbox"/> 2 times per day <input type="checkbox"/> Every 2 hours <input type="checkbox"/> Once per day <input type="checkbox"/> 6 times per day <input type="checkbox"/> Once every other day <input type="checkbox"/> 4 times per day <input type="checkbox"/> Unknown <input type="checkbox"/> 3 times per day <input type="checkbox"/> No <input type="checkbox"/> Unknown
7 Is subject currently using topical steroid drops?	<input type="checkbox"/> Yes → If Yes: What is current frequency (check one)? <input type="checkbox"/> Hourly <input type="checkbox"/> 2 times per day <input type="checkbox"/> Every 2 hours <input type="checkbox"/> Once per day <input type="checkbox"/> 6 times per day <input type="checkbox"/> Once every other day <input type="checkbox"/> 4 times per day <input type="checkbox"/> Unknown <input type="checkbox"/> 3 times per day How long has subject been on this dose? <input type="checkbox"/> < 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> >3-6 months <input type="checkbox"/> >6-12 months <input type="checkbox"/> >12 months <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown
8 Has subject used topical mydriatics since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
9 Has subject used topical anti-glaucoma drops since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
10 Has subject had eye surgery since the last study visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown