

The STANFORD HEALTH ASSESSMENT QUESTIONNAIRE©
Stanford University School of Medicine, Division of Immunology & Rheumatology

HAQ Disability Index:

In this section we are interested in learning how your illness affects your ability to function in daily life. Please feel free to add any comments on the back of this page.

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

	<u>Without ANY</u> <u>difficulty</u> ⁰	<u>With SOME</u> <u>difficulty</u> ¹	<u>With MUCH</u> <u>difficulty</u> ²	<u>UNABLE</u> <u>to do</u> ³
DRESSING & GROOMING				
Are you able to:				
-Dress yourself, including tying shoelaces and doing buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARISING				
Are you able to:				
-Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EATING				
Are you able to:				
-Cut your meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING				
Are you able to:				
-Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

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

	Without ANY difficulty ⁰	With SOME difficulty ¹	With MUCH difficulty ²	UNABLE to do ³
HYGIENE				
Are you able to:				
-Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACH				
Are you able to:				
-Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GRIP				
Are you able to:				
-Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Open jars which have been previously opened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACTIVITIES				
Are you able to:				
-Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Do chores such as vacuuming or yardwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | |
|--|--|
| <input type="checkbox"/> Raised toilet seat | <input type="checkbox"/> Bathtub bar |
| <input type="checkbox"/> Bathtub seat | <input type="checkbox"/> Long-handled appliances for reach |
| <input type="checkbox"/> Jar opener (for jars previously opened) | <input type="checkbox"/> Long-handled appliances in bathroom |
| | <input type="checkbox"/> Other (Specify: _____) |

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

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

6. Ethnicity (Initial form only)

Which ethnic group do you belong to?
Mark the space or spaces which apply to you.

- NZ European
- Māori
- Samoan
- Cook Island Maori
- Tongan
- Niuean
- Chinese
- Indian
- other (such as *DUTCH, JAPANESE, TOKELAUAN*). Please state:

--

Ko tēhea momo tāngata e whai pānga atu ana koe? Tohua te katoa o raro nei e hāngai ana ki a koe.

- Pākehā
- Māori
- Hāmoa
- Māori Kuki Airani
- Tonga
- Niue
- Hainamana
- Īnia
- tētahi atu (pērā i *TATIMANA, HAPANĪHI, TOKELAU*). Tuhia mai:

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NZRA Biologics Register – Initial Application

Name	DOB
Address	NHI
	Male/female
Rheumatologist	GP
Patient contact number	

Date: ___/___/___

1. Year of diagnosis □ □ □ □

2. Current disease activity

ESR □ □ □ Date ___/___/___

CRP □ □ □ Date ___/___/___

3. Physicians global assessment: mm

Very good _____ Very bad

4. Did the patient have a CXR prior to starting biological therapy? YES / NO

5. Did the patient have a Mantoux prior to starting biological therapy? YES / NO

6. Did the patient have a Quantiferon test prior to starting biological therapy? YES / NO

7. Please list the current medications and doses

DRUG	dose
Methotrexate	
Salazopyrin	
Hydroxychloroquine	
Leflunomide	
IM Gold	
Oral gold	
Cyclosporin	
Azathioprine	
Penicillamine	
Prednisone	
Other (please list)	

Please indicate which joints are swollen and or tender by placing an S and/or T in the boxes

					TMJ					
					C spine					
					Sternoclavicular					
					ACJ					
					Shoulder					
					Elbow					
					Wrist					
5	4	3	2	1	MCP	1	2	3	4	5
5	4	3	2	1	PIP	1	2	3	4	5
5	4	3	2		DIP		2	3	4	5
					Hip					
					Knee					
					Ankle					
					Midtarsal					
5	4	3	2	1	MTP	1	2	3	4	5
5	4	3	2	1	IP	1	2	3	4	5

Please send completed forms to Dr A Harrison, Department of Rheumatology, Hutt Hospital, Lower Hutt

NZRA Biologics Register – Renewal Application

Name	DOB
Address	NHI
	Male/female
Rheumatologist	GP
Patient contact number	

Date: ___/___/___

1. Date commenced biological therapy ___/___/___

2. Current disease activity

ESR

--	--	--

Date ___/___/___

CRP

--	--	--

Date ___/___/___

3. Physicians global assessment:

Very good _____

Very bad

mm

4. Physicians assessment of response to biological therapy

Very good _____

Very bad

mm

5. Is the patient continuing with biological therapy? YES / NO

IF no please indicate reason for discontinuation

Ineffective

Adverse event _____ (NB all serious adverse events should be reported to the Centre for Adverse Reactions Monitoring (CARM))

Other _____

6. Has there been a change in DMARD therapy since the last approval YES / NO

7. **If yes** please indicate the change

DRUG	Stopped	Dose reduction
Methotrexate		
Salazopyrin		
Hydroxychloroquine		
Leflunomide		
IM Gold		
Cyclosporin		
Azathioprine		
Penicillamine		
Prednisone		
Other		

Please indicate which joints are swollen and or tender by placing an S and/or T in the boxes

					TMJ					
					C spine					
					Sternoclavicular					
					ACJ					
					Shoulder					
					Elbow					
					Wrist					
5	4	3	2	1	MCP	1	2	3	4	5
5	4	3	2	1	PIP	1	2	3	4	5
5	4	3	2		DIP		2	3	4	5
					Hip					
					Knee					
					Ankle					
					Midtarsal					
5	4	3	2	1	MTP	1	2	3	4	5
5	4	3	2	1	IP	1	2	3	4	5

Please send completed forms to Dr A Harrison, Department of Rheumatology, Hutt Hospital, Lower Hutt