Patient Health and Lifestyle Questionnaire

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NIHR | BioResource

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IBD

This form will be scanned. Please answer ALL questions by using BLOCK CAPITALS in the spaces provided or crossing the relevent boxes. e.g. A B 1 2 ***Or*** ☒ Yes ☐ No

1. DEMOGRAPHICS

a. Your Height
(please specify units) ☐☐.☐☐ ☐ Metres & cm ***Or*** ☐ Feet & Inches

b. Your Weight
(only one measurement type is required) ☐☐☐ kg ***Or*** ☐☐☐ st ☐☐☐ lbs

c. Are you right or left handed? ☐ Right ☐ Left ☐ Both / Ambidextrous

d. Your date of birth D D / M M / Y Y Y Y

e. Your gender ☐ Male ☐ Female

f. What is your employment status? ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Unemployed

g. Do you have a specific diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Pescetarian
☐ Other - please specify

2. IBD SPECIFIC HEALTH QUESTIONS

a. What type of inflammatory bowel disease are you affected by?

Crohn's disease	☐
Ulcerative colitis	☐
IBD type unspecified	☐
Unsure	☐

b. Approximate month and year of diagnosis M M / Y Y Y Y

c. Approximate month and year of first symptoms M M / Y Y Y Y

d. Have you ever been admitted to hospital for treatment of Crohn's / Ulcerative Colitis? ☐ Yes ☐ No ☐ Don't know

e. Have you had your appendix out? ☐ Yes ☐ No ☐ Don't know

if yes, what year did you have your appendix out? Y Y Y Y

Continue overleaf...

f. Have you ever had perianal abscess or fistula? (an abscess next to your anus discharging pus or requiring antibiotics)
☐ Yes ☐ No ☐ Don't know

g. Were you taking anti-inflammatory pain killers on a daily basis for more than a week in the 3 months prior to onset of your IBD symptoms?
☐ Yes ☐ No ☐ Don't know

If Yes, which anti-inflammatory painkillers have you been taking?

☐ Brufen
☐ Nurofen
☐ Naproxen
☐ Voltarol
☐ Etodolac
☐ Other *please specify below.*

☐ Don't know

h. Were you taking oral /IV antibiotics on a daily basis for more than a week in the 3 months prior to onset of your IBD symptoms?
☐ Yes ☐ No ☐ Don't know

i. Were you taking oral contraceptives on a daily basis for more than one week in the 3 months prior to onset of your IBD symptoms?
☐ Yes ☐ No ☐ Don't know

3. GENERAL HEALTH QUESTIONS

a. Have you been diagnosed with any of the following?

				Year diagnosed (Y Y Y Y)	Further details
Allergy	☐ Yes	☐ No	☐ Don't know		☐ Aspirin ☐ Pollen ☐ Dairy ☐ Shellfish ☐ Latex ☐ Wheat ☐ Nuts/Seeds ☐ Multiple ☐ Penicillin ☐ Other
Ankylosing spondylitis	☐ Yes	☐ No	☐ Don't know		
Arthritis	☐ Yes	☐ No	☐ Don't know		☐ Rheumatoid ☐ Other ☐ Osteo
Asthma	☐ Yes	☐ No	☐ Don't know		
Atrial fibrillation	☐ Yes	☐ No	☐ Don't know		

Continue overleaf...

				Year diagnosed (Y Y Y Y)	Further details
Cancer *If Yes, please indicate which type*	☐ Yes	☐ No	☐ Don't know		☐ Lung ☐ Lymphoma ☐ Breast ☐ Prostate ☐ Bowel/Rectal ☐ Other ☐ Stomach ☐ Multiple ☐ Skin
Coeliac disease	☐ Yes	☐ No	☐ Don't know		
Diabetes *If Yes, please indicate which type* *Taking Insulin?*	☐ Yes ☐ Yes	☐ No ☐ No	☐ Don't know ☐ Don't know		☐ Type 1 ☐ Both ☐ Type 2 ☐ Don't know
Eczema	☐ Yes	☐ No	☐ Don't know		
Heart disease *If Yes, please indicate which type*	☐ Yes	☐ No	☐ Don't know		☐ Heart attack *e.g. Myocardial infarction* ☐ Coronary artery disease *e.g. angina* ☐ Heart failure ☐ Other
High blood pressure	☐ Yes	☐ No	☐ Don't know		
High cholesterol	☐ Yes	☐ No	☐ Don't know		
Multiple sclerosis	☐ Yes	☐ No	☐ Don't know		
Psoriasis	☐ Yes	☐ No	☐ Don't know		
Stroke	☐ Yes	☐ No	☐ Don't know		
Thyroid disease *If Yes, please indicate which type*	☐ Yes	☐ No	☐ Don't know		☐ Under active ☐ Over active
Vitiligo	☐ Yes	☐ No	☐ Don't know		

b. Have you had a neurological disorder? E.g. Brain tumour, epilepsy ☐ Yes ☐ No ☐ Don't know

c. Do you have metal implants anywhere in your body (excluding normal dental fillings) e.g. pacemakers, aneurysm clips, cochlear implants or have you suffered an injury involving metal fragments? ☐ Yes ☐ No ☐ Don't know

Continue overleaf...

d. Please list any other medical conditions

☐ Depression ☐ Fibromyalgia ☐ Glaucoma ☐ Migraines ☐ Osteoporosis ☐ Arthritis (including gout)

☐ Multiple ☐ Other

4. IBD SPECIFIC MEDICATION

Please tell us if you **are currently** on any medication listed below:

Azathioprine	☐ Yes	☐ No	☐ Don't know
Mercaptopurine (6-MP)	☐ Yes	☐ No	☐ Don't know
Methotrexate	☐ Yes	☐ No	☐ Don't know
Ciclosporin	☐ Yes	☐ No	☐ Don't know
Infliximab (e.g. Remicade, inflectra) - infusions	☐ Yes	☐ No	☐ Don't know
Adalimumab (e.g. Humira) - home injection	☐ Yes	☐ No	☐ Don't know
Vedolizumab (Entyvio)	☐ Yes	☐ No	☐ Don't know
Mesalazine - rectal	☐ Yes	☐ No	☐ Don't know
Mesalazine - oral	☐ Yes	☐ No	☐ Don't know
Sulphasalazine (Salazopyrin)	☐ Yes	☐ No	☐ Don't know
Steroids - oral *(Prednisolone, Budesonide, Entocort, Budenofalk or Cortiment)*	☐ Yes	☐ No	☐ Don't know
Steroids - rectal *(Predsol suppositories, predsol enemas, Predfoam, Colifoam, Budenofalk foam)*	☐ Yes	☐ No	☐ Don't know
Tioguanine	☐ Yes	☐ No	☐ Don't know
Allopurinol	☐ Yes	☐ No	☐ Don't know
Tacrolimus	☐ Yes	☐ No	☐ Don't know
Ustekinumab (Stellara) - home injections	☐ Yes	☐ No	☐ Don't know
Tofacitinib	☐ Yes	☐ No	☐ Don't know

5. ALCOHOL

a. Do you consume alcohol? ☐ Yes ☐ No - Continue to 6

b. If Yes, please give approximate number of units you consume per week
(1 pint of beer is 2 units and one small glass of wine is 1.5 units)

☐ 0-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31+

6. SMOKING

Do you smoke cigarettes? ☐ Yes - Continue with a. ☐ No - Continue with b.

a. If Yes, how many cigarettes per day?

☐ Less than 5 ☐ 5-10 ☐ 11-20 ☐ 21-30 ☐ 31-40 ☐ 41+

how many years have you smoked for? ☐☐ Years

b. If No, have you smoked in the past? ☐ Yes ☐ No - Continue with c.

If Yes, how many cigarettes per day?

☐ Less than 5 ☐ 5-10 ☐ 11-20 ☐ 21-30 ☐ 31-40 ☐ 41+

how many years did you smoked for? ☐☐ Years

what year did you give up? ☐☐☐☐

c. How many hours per week are you exposed to other people's tobacco smoke? *(passive smoking)* ☐☐☐ Hours

d. What was your smoking status at the time of IBD diagnosis?

☐ Smoker ☐ Had quit smoking ☐ Had never smoked

7. REGARDING YOUR PARTICIPATION IN FUTURE RESEARCH

a. Are you willing to provide blood samples? ☐ Yes ☐ No

b. Would you be willing to participate in studies of a commercial nature? ☐ Yes ☐ No
e.g. Studies which might involve in the development of new drugs by pharmaceutical companies

c. Are you willing to travel to your nearest clinical research facility? ☐ Yes ☐ No
(Travel costs will be reimbursed)

d. Are you currently participating (within the last 3 months) in any other research study? ☐ Yes ☐ No

If Yes, please indicate type of study (eg. questionnaire, physical exercise, blood studies, drug testing, MRI etc.)

8. FAMILY

(Please include all blood relatives, both living and deceased - but not adopted relatives, step children etc.)

a. How many children do you have? ☐☐ Son(s) ☐☐ Daughter(s)

b. How many brothers and sisters do you have?

☐☐ Brothers ☐☐ Sisters ☐☐ Half-brothers ☐☐ Half-sisters

c. Do you have a twin brother or sister? ☐ Yes ☐ No - Continue to 9

If Yes, is your twin? ☐ Identical ☐ Non-identical ☐ Not known

does your twin have IBD? ☐ Yes ☐ No ☐ Don't know

9. FAMILY HISTORY OF INFLAMMATORY BOWEL DISEASE

a. How many people do you currently live with who **do not** have Crohn's or Ulcerative Colitis?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+ ☐ Unknown

b. How many unaffected brothers and sisters do you have? *(who do not have either Crohn's or ulcerative colitis)*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+ ☐ Unknown

c. Have any of your family first/second degree blood relatives *(parents, brothers, sisters, children, uncles, aunts, cousins, grandparents)* ever been diagnosed with:

i. Crohn's ☐ Yes *- please specify below* ☐ No ☐ Don't know } *- go to ii.*

ii. Ulcerative colitis ☐ Yes *- please specify below* ☐ No ☐ Don't know } *- go to 10*

Mother	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Father	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Brother 1	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Brother 2	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Sister 1	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Sister 2	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Child 1	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Child 2	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Cousin	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Grandparent	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Uncle	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs
Aunt	☐ Crohn's	☐ Ulcerative Colitis	At age: ☐☐ yrs

10. FAMILY HISTORY OF CORONARY ARTERY DISEASE / STROKE

a. Have any of your **first degree** blood relatives *(parents, brothers, sisters, children)* ever been diagnosed with:

i. Coronary artery disease ☐ Yes *- please specify below*
☐ No
☐ Don't know } *- go to ii.*

Mother	☐ Coronary artery disease	At age:	yrs
Father	☐ Coronary artery disease	At age:	yrs
Brother 1	☐ Coronary artery disease	At age:	yrs
Brother 2	☐ Coronary artery disease	At age:	yrs
Sister 1	☐ Coronary artery disease	At age:	yrs
Sister 2	☐ Coronary artery disease	At age:	yrs
Child 1	☐ Coronary artery disease	At age:	yrs
Child 2	☐ Coronary artery disease	At age:	yrs

ii. Stroke ☐ Yes *- please specify below*
☐ No
☐ Don't know } *- go to 11*

Mother	☐ Stroke	At age:	yrs
Father	☐ Stroke	At age:	yrs
Brother 1	☐ Stroke	At age:	yrs
Brother 2	☐ Stroke	At age:	yrs
Sister 1	☐ Stroke	At age:	yrs
Sister 2	☐ Stroke	At age:	yrs
Child 1	☐ Stroke	At age:	yrs
Child 2	☐ Stroke	At age:	yrs

11. FAMILY HISTORY OF DIABETES (TYPES 1 AND 2)

a. Have any of your **first degree** blood relatives *(parents, brothers, sisters, children)* ever been diagnosed with:

Diabetes (type 1 and 2) ☐ Yes, type 1 *- please specify below*
☐ Yes, type 2 *- please specify below*
☐ No
☐ Don't know } *- go to 12*

	Diabetes type		*Approx. age at diagnosis*		*Have they received uninterrupted Insulin injections since diagnosis?*		
Mother	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Father	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Brother 1	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Brother 2	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Sister 1	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Sister 2	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Child 1	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know
Child 2	☐ Type 1	☐ Type 2	At age:	yrs	☐ Yes	☐ No	☐ Don't know

12. FAMILY HISTORY OF CANCER

a. Have any of your **first degree** blood relatives *(parents, brothers, sisters, children)* ever been diagnosed with:

Cancer ☐ Yes *- please specify below*
☐ No
☐ Don't know

	Please indicate which family member(s)	*Approx. age at diagnosis*	*Please indicate which type of cancer*		
Mother	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Father	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Brother 1	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Brother 2	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Sister 1	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Sister 2	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Child 1	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple
Child 2	☐	At age: ☐☐ yrs	☐ Lung ☐ Breast ☐ Bowel/Rectal	☐ Stomach ☐ Skin ☐ Lymphoma	☐ Prostate ☐ Other ☐ Multiple

Thank you very much for taking the time to complete this questionnaire

If you have any queries concerning this questionnaire please feel free to contact the IBD/NIHR BioResource team:

Telephone: 0800 090 2277
Email: ibd@bioresource.nihr.ac.uk