Patient Reported Outcome Measure Survey

Todays Date: D D / M M / Y Y Y Y

PLACE PATIENT IDENTIFICATION LABEL HERE
Or fill out necessary fields below

Name:

DOB (dd/mm/yyyy):

PHN:

EQ5D-5L

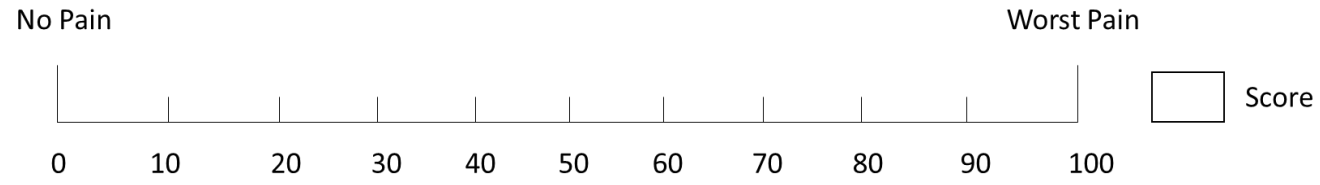
Under each heading, please check the ONE box that best describes your health TODAY.

Mobility				
◯ I have no problems in walking about	◯ I have slight problems in walking about	◯ I have moderate problems in walking about	◯ I have severe problems in walking about	◯ I am unable to walk about
Self-Care				
◯ I have no problems washing or dressing myself	◯ I have slight problems washing or dressing myself	◯ I have moderate problems washing or dressing myself	◯ I have severe problems washing or dressing myself	◯ I am unable to wash or dress myself
Usual Activities *(e.g. work, study, housework, family or leisure activities)*				
◯ I have no problems doing my usual activities	◯ I have slight problems doing my usual activities	◯ I have moderate problems doing my usual activities	◯ I have severe problems doing my usual activities	◯ I am unable to do my usual activities
Pain / Discomfort				
◯ I have no pain or discomfort	◯ I have slight pain or discomfort	◯ I have moderate pain or discomfort	◯ I have severe pain or discomfort	◯ I have extreme pain or discomfort
Anxiety / Depression				
◯ I am not anxious or depressed	◯ I am slightly anxious or depressed	◯ I am moderately anxious or depressed	◯ I am severely anxious or depressed	◯ I am extremely anxious or depressed

Subjective OA Performance Score

If you have more than one joint with osteoarthritis, please answer the next two questions considering all of your affected joints.

In the LAST TWO WEEKS, how much pain have you had in your affected joint(s) during your daily activities (up and down stairs, rising from sitting, getting in/out of bed), where 0 means no pain, and 100 means worst pain you can imagine? Circle your score on the scale OR write your score in the box to the right of the scale.



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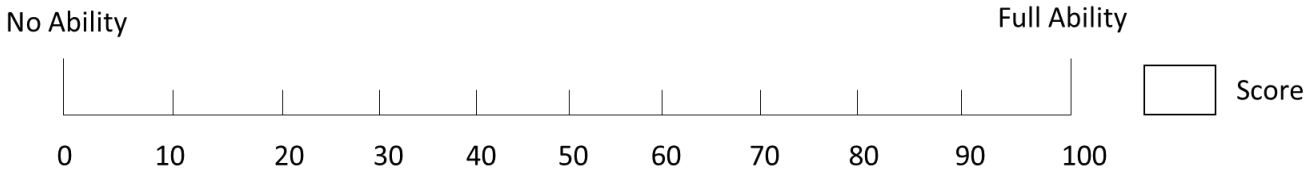
In the LAST TWO WEEKS, how much has your affected joint(s) impacted your ability to participate in your desired activities (e.g. your favourite sports or exercises classes, your outdoor activities, walking to a destination), where 0 means no ability, and 100 means full ability? Circle your score on the scale OR write your score in the box to the right of the scale.



PHQ-4

Are you avoiding ALL activities due to pain, stiffness, or weakness?	◯ **NO** ◯ **YES (if yes proceed with questions below)**

Under each question, please tick ONE box that describes your health over the last 2 weeks.

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?			
◯ Not at all	◯ Several Days	◯ More than half the day	◯ Nearly every day
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?			
◯ Not at all	◯ Several Days	◯ More than half the days	◯ Nearly every day
3. Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?			
◯ Not at all	◯ Several Days	◯ More than half the days	◯ Nearly every day
4. Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?			
◯ Not at all	◯ Several Days	◯ More than half the days	◯ Nearly every day