

Patient Health and Lifestyle Questionnaire

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NIHR | BioResource

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This form will be scanned. Please answer ALL questions by using BLOCK CAPITALS in the spaces provided or crossing the relevant boxes. e.g.

A	B	1	2
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Or Yes No

1. DEMOGRAPHICS

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

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

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

please specify what your job is / was:

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
 Not affected

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?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Y Y Y Y

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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 3 months prior to onset of your IBD symptoms? Yes No Don't know

if yes, what anti-inflammatory drug 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 three 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 three 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	Further details
				Y Y Y Y	
Allergy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Ankylosing spondylitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Atrial fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="checkbox"/> Lung <input type="checkbox"/> Breast <input type="checkbox"/> Bowel/Rectal <input type="checkbox"/> Stomach <input type="checkbox"/> Skin <input type="checkbox"/> Lymphoma <input type="checkbox"/> Prostate <input type="checkbox"/> Other

If Yes, please indicate which type

Continued overleaf...



General Health Questions continued...

				Year diagnosed	Further details
				Y Y Y Y	
Coeliac disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="checkbox"/> Type 1
	<i>If Yes, please indicate which type</i>				<input type="checkbox"/> Both
Taking Insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know		<input type="checkbox"/> Type 2
					<input type="checkbox"/> Don't know
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="checkbox"/> Heart attack e.g. MI
	<i>If Yes, please indicate which type</i>				<input type="checkbox"/> Coronary artery disease e.g. angina
					<input type="checkbox"/> Heart failure
					<input type="checkbox"/> Other
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Multiple sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="checkbox"/> Under active
	<i>If Yes, please indicate which type</i>				<input type="checkbox"/> Over active
Vitiligo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	<input type="text"/>

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

d. Please list any other medical conditions



4. IBD SPECIFIC MEDICATION

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

Azathioprine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
6 Mercaptopurine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Methotrexate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Ciclosporin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Infliximab (Remicade) - infusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Adalimumab (Humira) - home injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Vedolizumab (Entyvio) - infusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Mesalazine - rectal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sulphasalazine (Salazopyrin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Steroids- oral <i>(Prednisolone, Budesonide, Entocort, Budenofalk or Cortiment)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Steroids- rectal <i>(Predsol suppositories, predsol enemas, Predfoam, Colifoam, Budenofalk foam)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Tioguanine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Allopurinol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Tacrolimus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Ustekinumab (Stellara)-home injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know

5. GENERAL MEDICATION

Please tell us about any long-term medication that you are taking:

Name of medication	Type (tablets, inhaler etc)	Reason

Continue overleaf...

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General Medication continued...

Name of medication	Type (tablets, inhaler etc)	Reason

6. ALCOHOL

a. Do you consume alcohol? Yes No - Continue to 7

b. If Yes, please give approximate number of units you consume per week
(1 pint of beer is 3 units and one small glass of wine is 2 units)

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

7. 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

8. 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?
e.g. Studies with pharmaceutical companies. Yes No

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

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.)



9. 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 10
- If Yes, is your twin? Identical Non-identical Not known
- does your twin have IBD? Yes No Don't know

10. 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, siblings, children, 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 11*

Mother	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Father	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Brother 1	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Brother 2	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Sister 1	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Sister 2	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Child 1	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Child 2	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Cousin 1	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Cousin 2	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Grandparent 1	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Grandparent 2	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs



11. 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.

- ii. Stroke Yes - *please specify below*
 No
 Don't know } - go to 12

Mother	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Father	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Brother 1	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Brother 2	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Sister 1	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Sister 2	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Child 1	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs
Child 2	<input type="checkbox"/> Coronary artery disease	At age:	<input type="text"/>	<input type="text"/>	yrs

Mother	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Father	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Brother 1	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Brother 2	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Sister 1	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Sister 2	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Child 1	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs
Child 2	<input type="checkbox"/> Stroke	At age:	<input type="text"/>	<input type="text"/>	yrs

12. 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 13

	Diabetes type		Approx. age at diagnosis	Have they received uninterrupted Insulin injections since diagnosis?					
Mother	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Father	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Brother 1	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Brother 2	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sister 1	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sister 2	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Child 1	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Child 2	<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	At age:	<input type="text"/>	<input type="text"/>	yrs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know



13. 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 } - go to 14

	<i>Please indicate which family member(s)</i>	<i>Approx. age at diagnosis</i>	<i>Briefly indicate which type of cancer</i>
Mother	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Father	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Brother 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Brother 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Sister 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Sister 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Child 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>
Child 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<input type="text"/>

14. GENERAL COMMENTS

Please add any other information that might be relevant.

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



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