

# 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 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 <sup>D</sup><sup>D</sup> / <sup>M</sup><sup>M</sup> / <sup>Y</sup><sup>Y</sup><sup>Y</sup><sup>Y</sup>
- 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 <sup>M</sup><sup>M</sup> / <sup>Y</sup><sup>Y</sup><sup>Y</sup><sup>Y</sup>
- c. Approximate month and year of first symptoms <sup>M</sup><sup>M</sup> / <sup>Y</sup><sup>Y</sup><sup>Y</sup><sup>Y</sup>
- 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? <sup>Y</sup><sup>Y</sup><sup>Y</sup><sup>Y</sup>

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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 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						
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	Y Y Y Y		Further details				
Allergy				<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					<input type="checkbox"/> Aspirin <input type="checkbox"/> Dairy <input type="checkbox"/> Latex <input type="checkbox"/> Nuts/Seeds <input type="checkbox"/> Penicillin	<input type="checkbox"/> Pollen <input type="checkbox"/> Shellfish <input type="checkbox"/> Wheat <input type="checkbox"/> Multiple <input type="checkbox"/> Other
Ankylosing spondylitis				<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
Arthritis				<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					<input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteo	<input type="checkbox"/> Other
Asthma				<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
Atrial fibrillation				<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						

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				Year diagnosed	Further details
				Y Y Y Y	
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
<i>If Yes, please indicate which type</i>					<input type="checkbox"/> Lymphoma <input type="checkbox"/> Prostate <input type="checkbox"/> Other <input type="checkbox"/> Multiple
Coeliac disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<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 <input type="checkbox"/> Type 2
<i>If Yes, please indicate which type</i>					<input type="checkbox"/> Both <input type="checkbox"/> Don't know
Taking Insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know		
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<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 <i>e.g. Myocardial infarction</i> <input type="checkbox"/> Heart failure
<i>If Yes, please indicate which type</i>					<input type="checkbox"/> Coronary artery disease <i>e.g. angina</i> <input type="checkbox"/> Other
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	
Multiple sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	
Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<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 <input type="checkbox"/> Over active
<i>If Yes, please indicate which type</i>					
Vitiligo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="text"/>	
b. Have you had a neurological disorder? E.g. Brain tumour, epilepsy					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know					

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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?  
*e.g. Studies which might involve in the development of new drugs by 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.)



## 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	<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	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Grandparent	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Uncle	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> yrs
Aunt	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Ulcerative Colitis	At age: <input type="text"/> <input type="text"/> 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.

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

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

## 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	<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



## 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

	<i>Please indicate which family member(s)</i>	<i>Approx. age at diagnosis</i>	<i>Please indicate which type of cancer</i>		
Mother	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Father	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Brother 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Brother 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Sister 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Sister 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Child 1	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> Multiple
Child 2	<input type="checkbox"/>	At age: <input type="text"/> <input type="text"/> yrs	<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 <input type="checkbox"/> 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](mailto:ibd@bioresource.nihr.ac.uk)

