



Study #021

Plate #436

Seq #005

Participant ID # - -

Today's Date
 day month year

Follow-up Rheumatoid Arthritis (RA) Diagnosis Confirmation Form

For each of the following criteria, indicate whether the participant has the condition:

- | | | yes | no |
|-------------|--|------------------------|------------------------|
| frd1 | 1. Morning stiffness | <input type="text"/> 1 | <input type="text"/> 2 |
| frd2 | 2. Arthritis of three or more joints | <input type="text"/> 1 | <input type="text"/> 2 |
| frd3 | 3. Arthritis of hand joints | <input type="text"/> 1 | <input type="text"/> 2 |
| frd4 | 4. Symmetric arthritis. | <input type="text"/> 1 | <input type="text"/> 2 |
| frd5 | 5. Rheumatoid nodules | <input type="text"/> 1 | <input type="text"/> 2 |
| frd6 | 6. Serum rheumatoid factor. | <input type="text"/> 1 | <input type="text"/> 2 |
| frd7 | 7. Radiographic changes. | <input type="text"/> 1 | <input type="text"/> 2 |

- | | | yes | no |
|-------------|---|------------------------|------------------------|
| frd8 | 8. Does the participant meet ACR criteria for Rheumatoid Arthritis? | <input type="text"/> 1 | <input type="text"/> 2 |

Go to item 9

frd8a 8a. Year of RA diagnosis:

frd9 9. Physician Confirmation of RA Diagnosis form completed by:

- 1 Rheumatologist
 2 Orthopedist
 3 Internist
 4 Other; specify: frd9_sp