

The ANCA-associated Vasculitis Patient-Reported Outcome (AAV-PRO) Questionnaire

SAMPLE

AAV-PRO Questionnaire

Symptoms

Due to having vasculitis or its treatment, please rate your experience of the following problems, in general, during the past 4 weeks.

Please ✓ **only one box** for each statement.

	None	Very mild	Mild	Moderate	Severe
1. Chest problems (such as wheezing, 'chest tightness', coughing, or shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Problems with your ears (such as pain, difficulty hearing, a sense of pressure, or blockage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Problems with your eyes (such as pain, blurred or poor vision, or sensitivity to light)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Problems with your nose or sinuses (such as pain, a sense of pressure, nosebleeds, blockage, runny nose, or crusting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Problems with your mouth or throat (such as dryness, mouth sores, hoarseness, sore throat, or difficulty eating/swallowing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Problems with your joints (such as aches and pains or swelling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pain, cramps or weakness affecting your muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Problems with your skin (such as swelling, blotches, a rash, bruising, or lumps)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Tiredness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Feeling uncomfortably hot, cold, or feverish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Indigestion, heartburn, nausea, or sickness (vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Difficulties with everyday life

Due to having vasculitis or its treatment, how difficult have you found the following activities, in general, during the past 4 weeks?

Please ✓ **only one box** for each statement.

	No difficulty	A little difficult	Moderately difficult	Extremely difficult	I could not do this
12. Walking around shops for <u>at least</u> an hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Walking up a flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Doing the physical activities that you wanted to (such as walking, sports, or fitness classes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Washing and drying yourself, or getting dressed, <u>without help</u> from another person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Getting enough good sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social and emotional impact

Due to having vasculitis or its treatment, how often have the following applied to you, in general, during the past 4 weeks?

Please ✓ **only one box** for each statement.

	None of the time	Rarely	Sometimes	Often	All of the time
17. I have felt concerned about my weight (weight gain or weight loss)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I have felt upset or frustrated because I have been unable to work or do my everyday tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social and emotional impact *(continued)*

Due to having vasculitis or its treatment, how often have the following applied to you, in general, during the past 4 weeks?

Please ✓ **only one box** for each statement.

	None of the time	Rarely	Sometimes	Often	All of the time
19. I have worried about what will happen to me in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I have been anxious, worried or stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I have had difficulty concentrating or being focussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I have felt down or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I have worried about being dependent on other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I have had difficulty making <u>long-term</u> plans (for example, plans involving work, close relationships, or family)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I have worried about travelling a long distance from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I have felt embarrassed or self-conscious due to my appearance or symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I have felt that I have let other people down (for example, because you couldn't provide help, or had to cancel an arrangement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I have felt that my life is now focussed on coping with my condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I have worried about the long-term effects of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>