Please complete or attach patient sticker:

Name:

Hosp. No.:

NHS/CHI:

DoB:

Gender: ☐ Male ☐ Female

Address:

BIR Biologic Interventions Register

BADBIR ID: ☐☐☐☐☐☐☐☐☐

BAD Biologic Interventions Register Baseline Clinical Questionnaire

Today's Date:_____ **Date of Consent:**_____ **Sent to BADBIR?** ☐

Date Entered on to Database:_____ **Biologic Cohort** ☐ **Conventional Cohort** ☐

Psoriasis

1. Does the patient have a past history of the following?

	Yes	No
Erythrodermic psoriasis	☐	☐
Generalised pustular psoriasis	☐	☐

2. What type of psoriasis does the patient currently have?

	Yes	No	
Chronic plaque psoriasis	☐	☐	→ **Small** (≤3cm diam) ☐ **Large** (>3cm diam) ☐
Flexural/intertriginous	☐	☐	
Seborrhoeic psoriasis	☐	☐	
Scalp	☐	☐	
Palms/soles (non pustular)	☐	☐	
Nails	☐	☐	→ Indicate number of nails affected ☐
Guttate psoriasis	☐	☐	
Unstable psoriasis	☐	☐	
Erythrodermic	☐	☐	
Generalised pustular psoriasis	☐	☐	
Localised pustular psoriasis	☐	☐	→ Acrodermatitis Hallopeau ☐ ☐ / Palmoplantar pustulosis ☐ ☐
Other (please specify below)	☐	☐	

☐

3. Please complete the following details:

Year of diagnosis (best approximation) ☐☐☐☐ Year first seen by a dermatologist ☐☐☐☐

4. Does the patient have a family history of psoriasis? (i.e. first-degree relative such as parent, sibling or child)

Yes ☐
No ☐
Don't know ☐

Disease Severity

5. Does the patient have diagnosis by a rheumatologist of psoriatic arthritis? Yes ☐ → ☐☐☐☐ Year of Diagnosis
No ☐

Please add details of any other inflammatory arthritis conditions to comorbidities

6. Please indicate the current disease severity (i.e. at the time the patient started the new drug)

Preferably a PASI from within 3 months prior to drug commencement

PASI ☐☐ ☐ **BSA** ☐☐ ***Only if the patient has pustular psoriasis,***

Date of PASI …../……/…… **Date of BSA** …../……/……

Psoriasis Global Assessment:

☐	Severe	☐	Mild
☐	Moderate to severe	☐	Almost clear
☐	Moderate	☐	Clear

Missing: ☐

Current Drug Therapy

7. Is the patient currently on any of the following topical treatments?

Topical pimecrolimus Yes ☐ No ☐ **Topical tacrolimus** Yes ☐ No ☐

8. Please list all the patient's current therapy for any *indication (Please note topical treatments apart from the two listed above are not required)*

DRUG	Date Started (d d m m y y)	DRUG	Date Started (d d m m y y)
_____		_____	
_____		_____	
_____		_____	
_____		_____	

BIOLOGIC / IMMUNOMODULATOR COHORT ONLY: *Please remember to list any systemic treatments the patient may*

Biologic Therapy

Please enter the patients current biologic therapy

Benepali (etanercept) ☐ **Stelara (ustekinumab)** ☐ **Taltz (ixekizumab)** ☐

Cosentyx (secukinumab) ☐ **Humira (adalimumab)** ☐ Dose **and** Frequency: ……mg ……..

Commencement date of this episode of biologic therapy (d d m m y y) Batch Number:

STELARA ONLY: Provide administration dates

d d	m m	y y	Batch Number

HUMIRA ONLY: Did the patient receive the 80mg loading dose?
Yes ☐ **No** ☐

TALTZ ONLY: Was the recommended opening schedule followed? (i.e. 160mg at week 0, 80mg at weeks 2, 4, 6, 8, 10, and 12)
Yes ☐ **No** ☐ **Currently Unknown** (will advise at next follow-up) ☐

COSENTYX ONLY: Was the recommended opening schedule followed? (i.e. 300mg at weeks 0, 1, 2, 3 & 4)
Yes ☐ **No** ☐ **Currently Unknown** (will advise at next follow-up) ☐

If 'No' for **Taltz** or **Cosentyx**, please provide details of deviation from opening schedule:

Is this the patient's first exposure to a biologic agent?:

Yes ☐ No ☐

CONVENTIONAL COHORT ONLY: Please list all systemic treatment for psoriasis

Conventional Therapy

DRUG	(Please Tick)	J/cm² or mg	Frequency	Date Started (d d m m y y)
Oral PUVA				
Methotrexate				
Ciclosporin				
Acitretin				
Fumaderm				
Hydroxycarbamide				

Previous Therapy

9. Please list <u>all previous</u> systemic anti-psoriatic therapy: **If none please tick** ☐

Drug	Start date	Stop date	Stop reason

***Stop reasons** (may have than one reason) ((1) Inefficacy (2) Remission (3) Adverse Events (4) Inefficacy and Adverse Events (5) Patient Non-Compliance (6) Titration (7) Financial Consideration (8) Patient Choice (9) Other (please provide detail)*

Co-morbidities

10. Has the patient <u>ever</u> had (i.e. <u>required treatment for</u>) any of the following illnesses?

(please tick <u>all</u> that apply) **If none please tick** ☐

Hypertension	Yes	Year of Onset
Hypertension		

Cardiovascular Disease	Yes	Year of Onset
Angina		
Myocardial Infarction		
Stroke / Cerebrovascular Disease		
Peripheral Vascular Disease		
Dyslipidaemia		

Diabetes	Yes	Year of Onset
Type 1		
Type 2		

Autoimmune Disorders	Yes	Year of Onset
Thyroid Disease		
Alopecia Areata		
Vitiligo		
Psoriatic Arthritis		

Thrombosis	Yes	Year of Onset
Deep vein thrombosis		
Pulmonary embolism		
Asthma		
COPD (including chronic bronchitis, emphysema)		

Liver Disease	Yes	Year of Onset
NAFLD (non-alcoholic fatty liver disease, including fatty liver and NASH)		
Alcoholic Liver Disease		
Viral Hepatitis		
Autoimmune Hepatitis		
Inherited Liver Disease (inc. haemochromatosis)		

Kidney Disease	Yes	Year of Onset
Chronic Kidney Disease		
Glomerular Disease		
Renovascular Kidney Disease		
Inherited Renal Disease (polycystic kidney disease)		

Peptic Ulcer	Yes	Year of Onset
Peptic Ulcer		

Demyelination	Yes	Year of Onset
Optic Neuritis		
Multiple Sclerosis		
Transverse Myelitis		
Chronic Inflammatory De-myelinating Polyneuropathy		
Guillain-Barre Syndrome		

Epilepsy	Yes	Year of Onset
Epilepsy		

Peptic Ulcer	Yes	Year of Onset
Peptic Ulcer		

Non-Skin Cancer	Yes	Year of Onset
Please specify type / site:		

Psychiatric	Yes	Year of Onset
Depression		
Anxiety		

Inflammatory Bowel	Yes	Year of Onset
Crohns		
Ulcerative Colitis		

Other (please specify)	Yes	Year of Onset

Skin

Skin Cancer risk factors:

11a) Please indicate Fitzpatrick skin type in box below

Description	Fitzpatrick Skin Type	Please tick
Burns easily, never tans	**1**	
Burns easily, tans minimally	**2**	
Burns moderately, tans gradually	**3**	
Burns minimally, tans well	**4**	
Rarely burns, tans profusely	**5**	
Never burns, deeply pigmented	**6**	

11b) History of prior neoplastic or pre-cancerous lesions? Yes ☐ No ☐

(Please indicate number) and site below)

Type	Site	Number
SCC		
BCC		
Melanoma		
Melanoma in situ		
Actinic keratosis		
Bowen's disease		
Keratoacanthoma		

UV Therapy

12. Has the patient ever had UV therapy? Yes ☐ No ☐ **If YES, please complete the following:**

UV Therapy Details	Yes	No. of Courses	No. of Treatments	Cumulative Dose (J/cm^2)	Data Known to be Accurate?
Broadband UVB					
Narrowband UVB					
TOTAL BODY PUVA					
Oral PUVA					
Topical PUVA					
HAND AND FOOT PUVA					
Oral PUVA					
Topical PUVA					
UVA 1					

Lab Values

13. Please complete the following laboratory values (recent i.e. within last 6 months):

LABORATORY VALUES	Result	Date
Haemoglobin count (g/dL)		
White cell count (x10^9/L)		
Platelet count (x10^9/L)		
Creatinine (µmol/L)		
Transaminase ALT (U/L)		
Cholesterol (mmol/L)		
Triglyceride (mmol/L)		
HDL (mmol/L)		

Additional Information

14. What is the patient's current (i.e. at the time that the biologic/systemic agent was started) blood pressure?

Systolic ☐☐☐ mm

Diastolic ☐☐☐ mm

15. What is the patient's current (i.e. at the time that the biologic/systemic agent was started) height, weight and waist circumference?

Height ☐☐☐ cm

Weight ☐☐☐ kg

Waist ☐☐☐ cm

PBQ & QoL Questionnaires

The following patient questionnaires should also be completed:

PBQ ☐

(1)DLQI ☐

EuroQol ☐

CAGE ☐

(2)HAQ ☐

If paediatric patient:

cDLQI ☐

EQ-5D-y ☐

PBQ ☐

(2)cHAQ ☐

(1) It is not essential but a DLQI taken prior to drug commencement is preferred

(2) (Only if patient has a rheumatologist's diagnosis of inflammatory arthritis)

Signature

Please sign and date below:

Name: _____ **Signature:** _____ **Date:** _____