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|  |  |  |
| **IBD Control** |  |  |
| *Inflammatory Bowel Disease Control Questionnaire* |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | **Do you believe that :** |  |  |  | |
|  | 1. Your IBD has been well controlled in the past two weeks? | Yes | No | Not sure | |
|  | 1. Your current treatment is useful in controlling your IBD?   *(if you are not taking any treatment, please tick this box* □) | Yes | No | Not sure | |
| 2 | **Over the past 2 weeks, have your bowel symptoms been getting worse, getting better or not changed?** | Better | No change | | Not sure |
|  |
| 3 | **In the past 2 weeks did you :** |  |  |  | |
|  | 1. Miss any planned activities because of IBD ?   (e.g. attending school/college, going to work or a social event) | Yes | No | Not sure | |
|  | 1. Wake up at night because of symptoms of IBD ? | Yes | No | Not sure | |
|  | 1. Suffer from significant pain or discomfort ? | Yes | No | Not sure | |
|  | 1. Often feel lacking in energy (fatigued) ?   (by often we mean more than half of the time) | Yes | No | Not sure | |
|  | 1. Feel anxious of depressed because of your IBD ? | Yes | No | Not sure | |
|  | 1. Think you needed a change to your treatment ? | Yes | No | Not sure | |
| 4 | **At your next clinic visit, would you like to discuss:** |  |  |  | |
|  | a) Alternative types of drug for controlling IBD | Yes | No | Not sure | |
|  | b) Ways to adjust your own treatment | Yes | No | Not sure | |
|  | c) Side effects or difficulties with using your medicines | Yes | No | Not sure | |
|  | d) New symptoms that have developed since your last visit | Yes | No | Not sure | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5 | **How would you rate the OVERALL control of your IBD in the past *two* weeks?**  Please draw a vertical line (**I**) on the scale below | | | |
|  | **Worst**  **Best**  Possible ~~I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I~~ possible  Control |  |  |

EDMSIBDC Date :

**Harvey-Bradshaw Index (HBI) —**

**Crohn’s disease activity Score**

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of HBI calculation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check one box per number (except for # 5)

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | General well-being |  | Very well = 0 |
|  |  |  | Slightly below par = 1 |
|  |  |  | Poor = 2 |
|  |  | Very poor = 3 |
|  |  | Terrible = 4 |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. | Abdominal Pain |  | None = 0 |
|  |  |  | Mild - 1 |
|  |  |  | Moderate = 2 |
|  |  |  | Severe = 3 |

|  |  |  |
| --- | --- | --- |
| 3. | Number of liquid or soft stools per day | = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. | Abdominal mass |  | None = 0 |
|  |  |  | Dubious = 1 |
|  |  |  | Definite = 2 |
|  |  |  | Definite and tender = 3 |

|  |  |  |  |
| --- | --- | --- | --- |
| 5. | Complications  (Check any that apply; one  Per item except for first box) |  | None |
|  | Arthralgia |
|  | Uveitis |
|  |  |  | Erythema nodosum |
|  |  |  | Aphthous ulcers |
|  |  |  | Phoyderma gangrenosum |
|  |  |  | Anal fissure |
|  |  |  | New fistula |
|  |  |  | Abscess |

|  |  |  |  |
| --- | --- | --- | --- |
| 6. | **H**arvey-**B**radshaw **I**ndex score 2 = |  | |
|  | (please add scores of questions  1 through 5) | Remission | <5 |
|  | Mild disease | 5-7 |
|  | Moderate disease | 8-16 |
|  |  | Severe disease | >16 |