

MORPHEA Registry and DNA Repository

I have read the description of the study and I have decided to participate in the research project described here. I understand that I may refuse to answer any (or all) of the questions at this time or any other time. I understand that I will be contacted on an annual basis in the future about this, but that I am free to refuse any further participation if I wish.

Check the box next to the symptom you are experiencing and/or have experienced in the past.

- | | |
|---|--|
| <input type="checkbox"/> Decreased ability to conduct usual activities
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Changes in hair growth or loss
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Lymph node swelling
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: <u>(location)</u> _____
_____ |
| <input type="checkbox"/> Fever or night sweats
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Headaches
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Vision changes or pain in eye(s)
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Dental difficulties
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Seizures
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Problems swallowing food or liquids
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Feeling cold or hot tendency
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Color change in fingers in cold exposure
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |
| <input type="checkbox"/> Problems with clotting in blood vessels
<input type="checkbox"/> Currently experiencing
Duration: <input type="checkbox"/> yrs | Describe: _____
_____ |

Check the box next to the symptom you are experiencing and/or have experienced in the past.

- Changes in stool (color, blood) Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Rash or photosensitivity Describe: (location) _____
 Currently experiencing _____
Duration: yrs _____
- Chest pain or pain with respiration Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Joint changes (color, warmth, stiffness) Describe: (location) _____
 Currently experiencing _____
Duration: yrs _____
- Incoordination Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Previous transfusions Describe: _____
Dates
Number of times: _____
- Changes in urine (color, amount) Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Muscle pain Describe: (location) _____
 Currently experiencing _____
Duration: yrs _____
- Joint pain Describe: (location) _____
 Currently experiencing _____
Duration: yrs _____
- Numbness, tingling or altered sensation Describe: (location) _____
 Currently experiencing _____
Duration: yrs _____
- Neck or thyroid masses Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Yellow coloration to the skin/ jaundice Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Shortness of breath Describe: _____
 Currently experiencing _____
Duration: yrs _____
- Nail changes Describe: _____
 Currently experiencing _____
Duration: yrs _____

Please complete the following as thoroughly as possible.

1. Have you had any lab work as part of investigation of your morphea? No Yes Unsure

1a. If yes, was an anti-nuclear antibody (ANA) titer performed? No Yes Unsure

1b. If yes, was the titer elevated/positive (? 1:160)? No Yes Unsure

1c. If yes, what was the pattern? Homogenous/Diffuse Speckled
 Nucleolar Peripheral/Rim Unsure

2. Have you had any imaging (CT scan, MRI, ultrasound, X-ray) performed as part of the investigation of your morphea? No Yes Unsure

2a. If yes, please use the lines provided to describe (for each imaging procedure) the type of imaging technique, the date of service and the results of the test.

3. Please list your current medications.

Name	Dose (i.e. 50 milligrams)	Frequency (i.e. Twice a day)
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