PSC PATIENTS QUESTIONNAIRE

Family name: ..... **Given name**: .....

Sex: M / F

Date of birth: ...../...../..... *(dd/mm/yyyy)* **Place of birth**: .....

Date this questionnaire was completed: ...../...../..... *(dd/mm/yyyy)*

Address: .....

.....

Phone number/GSM: .....

E-mail: .....

General practitioner: *Name:* .....

Address: .....

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Hepatologist (if not in UZ Leuven): *Name:* .....

Hospital: .....

Address: .....

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1. You suffer from primary sclerosing cholangitis (PSC).

In which year was the diagnosis confirmed? ..... (*or age*: ..... *years*)

In which hospital was the diagnosis made? .....

By which physician was the diagnosis made? .....

2. Do you suffer from **any other disease(s)**? ☐ No ☐ Yes

If yes, which disease(s)? .....

3. Have you ever had a **venous thrombosis** (blood clot in a vein), an **embolus** or **phlebitis** (inflammation of a vein)? ☐ No ☐ Yes

4. Have you ever had one of the undermentioned problems **outside the gastrointestinal tract**?

☐ No ☐ Yes

If yes, check the appropriate box:

☐ aphthous ulcerations in the mouth (not lip herpes)

☐ eye inflammation (conjunctivitis, keratitis, uveitis, iritis)

☐ eczema, ☐ psoriasis, ☐ erythema nodosum, ☐ pyoderma gangrenosum

☐ joint pain, ☐ rheumatoid arthritis, ☐ sacroiliitis, ☐ anykylosing spondylitis (Bechterew's disease)

☐ anemia

☐ reduced bone density (osteoporosis , osteopenia)

☐ other: ……

5. Surgery.

Have you ever had an **appendectomy** (surgery for appendicitis)?

☐ No ☐ Yes, date …… *(year)*

Have you ever had **other intestinal surgery**?

☐ No ☐ Yes, number: ……

Surgery	Year	Description
1		
2		
3		
4		

Have you ever had a **liver transplant**?

☐ No ☐ Yes, number: ……

Surgery	Year	Reason for transplant
1		
2		
3		
4		

6. What is your **height**? …… cm

What is your current **weight**? …… kg

7. Which **medications** do you take for your **liver disease**?

……

……

8. Do you currently take any **medication for other purposes** (oral contraceptives included)?

☐ No ☐ Yes I*f yes, which medication?*

…… ……

…… ……

…… ……

9. Have you taken **antibiotics** in the past month? ☐ *No* ☐ *Yes*

If yes, which antibiotic(s)? ……

Duration of use (start and stop date): from …… / …… / …… *until* …… / …… / ……

10. Alcohol consumption. How often do you have a drink containing alcohol?

☐ Never

☐ Monthly or less - How many glasses of alcohol do you drink on average per month? …… (*number*)

☐ Weekly - How many glasses of alcohol do you drink on average per week? …… (*number*)

☐ Daily - How many glasses of alcohol do you drink on average per day? …… (*number*)

11. Smoking habits. *Please check the box or boxes that apply:*

☐ I have **NEVER** smoked.

☐ I am an **ACTIVE** smoker since the year…… (*or age:* …… *years*).

I smoke approximately …… (*number*) cigarettes per day.

I smoked at the moment when the diagnosis of PSC was made: ☐ No ☐ Yes

☐ I started smoking in the year…… (*or age:* …… *years*) and **QUIT** in the year…….

I smoked approximately …… (*number*) cigarettes per day.

I smoked at the moment when the diagnosis of PSC was made: ☐ No ☐ Yes

12. Do you follow a special **diet**? ☐ No ☐ Yes

If yes, specify diet: ……

13. Have you taken probiotics in the **last month**? ☐ No ☐ Yes

If yes, please mark which products you used, how frequent (how many days per week) en how long have you used it.

Probiotica	How frequent?	How long?
☐ Yakult	……	……
☐ Actimel (Danone)	……	……
☐ Activia (Danone)	……	……
☐ Essensis (Danone)	……	……
☐ Vifit (Campina)	……	……
☐ Optifit (Aldi)	……	……
☐ Proviact (Lidl)	……	……
☐ Nestlé	……	……
☐ VSL#3	……	……
☐ Products with 'bifidus' *(regular yogurt does not count!)*	……	……
☐ Other (which? ……)	……	……