Multi-Dimensional Health Assessment Questionnaire

Your Name _____ **Today's Date**_____

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel.

1. Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	_____0	_____1	_____2	_____3
b. Get in and out of bed?	_____0	_____1	_____2	_____3
c. Lift a full cup or glass to your mouth?	_____0	_____1	_____2	_____3
d. Walk outdoors on flat ground?	_____0	_____1	_____2	_____3
e. Wash and dry your entire body?	_____0	_____1	_____2	_____3
f. Bend down to pick up clothing from the floor?	_____0	_____1	_____2	_____3
g. Turn regular faucets on and off?	_____0	_____1	_____2	_____3
h. Get in and out of a car, bus, train, or airplane?	_____0	_____1	_____2	_____3
i. Walk two miles or three kilometers, if you wish?	_____0	_____1	_____2	_____3
j. Participate in recreational activities and sports as you would like, if you wish?	_____0	_____1	_____2	_____3
k. Get a good night's sleep?	_____0	_____1.1	_____2.2	_____3.3
l. Deal with feelings of anxiety or being nervous?	_____0	_____1.1	_____2.2	_____3.3
m. Deal with feelings of depression or feeling blue?	_____0	_____1.1	_____2.2	_____3.3

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please circle the appropriate number to indicate below how severe your pain has been:

NO PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 PAIN AS BAD AS IT COULD BE

3. Please circle the appropriate number to indicate the amount of pain you are having today in each of the joint areas listed below:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
a. LEFT FINGERS	0	1	2	3	i. RIGHT FINGERS	0	1	2	3
b. LEFT WRIST	0	1	2	3	j. RIGHT WRIST	0	1	2	3
c. LEFT ELBOW	0	1	2	3	k. RIGHT ELBOW	0	1	2	3
d. LEFT SHOULDER	0	1	2	3	l. RIGHT SHOULDER	0	1	2	3
e. LEFT HIP	0	1	2	3	m. RIGHT HIP	0	1	2	3
f. LEFT KNEE	0	1	2	3	n. RIGHT KNEE	0	1	2	3
g. LEFT ANKLE	0	1	2	3	o. RIGHT ANKLE	0	1	2	3
h. LEFT TOES	0	1	2	3	p. RIGHT TOES	0	1	2	3
q. NECK	0	1	2	3	r. BACK	0	1	2	3

4. Considering all the ways in which illness and health conditions may affect you at this time, please circle the appropriate number below to indicate how you are doing:

VERY WELL 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 VERY POORLY

Please turn to the other side

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1.a-j **FN** (0-10):

1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

2.**PN** (0-10):

4.**PTGL** (0-10):

RAPID 3 (0-30)

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = ≤3

5. Please check (√) if you have experienced any of the following <u>over the last month:</u>

__Fever	__Lump in your throat	__Numbness or tingling of arms or legs
__Weight gain (>10 lbs)	__Cough	__Fainting spells
__Weight loss (>10 lbs)	__Shortness of breath	__Swelling of hands
__Feeling sickly	__Wheezing	__Swelling of ankles
__Headaches	__Pain in the chest	__Swelling in other joints
__Unusual fatigue	__Heart pounding (palpitations)	__Back pain
__Swollen glands	__Trouble swallowing	__Neck pain
__Loss of appetite	__Heartburn or stomach gas	__Depression - feeling blue
__Skin rash or hives	__Stomach pain or cramps	__Anxiety - feeling nervous
__Unusual bruising or bleeding	__Nausea	__Problems with thinking
__Other skin problems	__Vomiting	__Problems with memory
__Loss of hair	__Constipation	__Problems with sleeping
__Dry eyes	__Diarrhea	__Problems with social activities
__Other eye problems	__Dark or bloody stools	
__Problems with hearing	__Problems with urination	
__Ringing in the ears	__Gynecological (female) problems	
__Stuffy nose	__Dizziness	
__Sores in the mouth	__Losing your balance	
__Dry mouth	__Muscle pain, aches, or cramps	
__Problems with smell or taste	__Muscle weakness	

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5. ROS: ☐

Please check (√) here if you have had none of the above over the last month: _____

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6. When you awoke in the morning OVER THE LAST WEEK, did you feel stiff? [Please circle] Yes No
If **"Yes," please indicate the number of minutes_____, or hours_____** until you are as limber as you will be for the day.

7. How do you feel TODAY compared to ONE WEEK AGO? Please circle only one.
Much **B**etter (1), **B**etter (2), the **S**ame (3), **W**orse (4), **M**uch **W**orse (5) than one week ago

8. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) **for at least one-half hour** (30 minutes)**? Please circle only one.**
3 or more times a week (3) 1-2 times per month (1)
1-2 times per week (2) Do not exercise regularly (0) Cannot exercise due to disability/ handicap (9)

9. How much of a problem has fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS NO PROBLEM 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 FATIGUE IS A MAJOR PROBLEM

10. Over the last 6 months have you had: [Please circle]

No	Yes	An operation or new illness	No	Yes	Change(s) of arthritis or other medication
No	Yes	Medical emergency or stay overnight in hospital	No	Yes	Change(s) of address
No	Yes	A fall, broken bone, or other accident or trauma	No	Yes	Change(s) of marital status
No	Yes	An important new symptom or medical problem	No	Yes	Change job or work duties, quit work, retired
No	Yes	Side effect(s) of any medication or drug	No	Yes	Change of medical insurance, Medicare, etc.
No	Yes	Smoke cigarettes regularly	No	Yes	Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

_____

_____

_____

_____

Your Name_____ **Today's Date** _____

Thank you for completing this questionnaire to help keep track of your medical care.