Print Form

Multi-Dimensional Health Assessment Questionnaire (R791-NP2)

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. <u>There are no right or wrong answers.</u> Please answer exactly as you think or feel. Thank you.

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

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

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

2.PN (0-10):

4.PTGL (0-10):

RAPID 3 (0-30)

2. How much pain have you had because of your condition OVER THE PAST WEEK? Please 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 place a check (√) in the appropriate spot 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
<u>a. LEFT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>i. RIGHT FINGERS</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>b. LEFT WRIST</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>j. RIGHT WRIST</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>c. LEFT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>k. RIGHT ELBOW</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>d. LEFT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>l. RIGHT SHOULDER</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>e. LEFT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>m. RIGHT HIP</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>f. LEFT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>n. RIGHT KNEE</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>g. LEFT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>o. RIGHT ANKLE</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>h. LEFT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>p. RIGHT TOES</u>	☐ 0	☐ 1	☐ 2	☐ 3
<u>q. NECK</u>	☐ 0	☐ 1	☐ 2	☐ 3	<u>r. BACK</u>	☐ 0	☐ 1	☐ 2	☐ 3

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below 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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5. Please check (√) if you have experienced any of the following over the last month:

☐ Fever	☐ Lump in your throat	☐ Paralysis of arms or legs
☐ Weight gain (>10 lbs)	☐ Cough	☐ Numbness or tingling of arms or legs
☐ Weight loss (<10 lbs)	☐ Shortness of breath	☐ Fainting spells
☐ Feeling sickly	☐ Wheezing	☐ Swelling of hands
☐ Headaches	☐ Pain in the chest	☐ Swelling of ankles
☐ Unusual fatigue	☐ Heart pounding (palpitations)	☐ Swelling in other joints
☐ Swollen glands	☐ Trouble swallowing	☐ Joint pain
☐ Loss of appetite	☐ Heartburn or stomach gas	☐ Back pain
☐ Skin rash or hives	☐ Stomach pain or cramps	☐ Neck pain
☐ Unusual bruising or bleeding	☐ Nausea	☐ Use of drugs not sold in stores
☐ Other skin problems	☐ Vomiting	☐ Smoking cigarettes
☐ Loss of hair	☐ Constipation	☐ More than 2 alcoholic drinks per day
☐ Dry eyes	☐ Diarrhea	☐ Depression - feeling blue
☐ Other eye problems	☐ Dark or bloody stools	☐ Anxiety - feeling nervous
☐ Problems with hearing	☐ Problems with urination	☐ Problems with thinking
☐ Ringing in the ears	☐ Gynecological (female) problems	☐ Problems with memory
☐ Stuffy nose	☐ Dizziness	☐ Problems with sleeping
☐ Sores in the mouth	☐ Losing your balance	☐ Sexual problems
☐ Dry mouth	☐ Muscle pain, aches, or cramps	☐ Burning in sex organs
☐ Problems with smell or taste	☐ Muscle weakness	☐ Problems with social activities

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5. ROS: ☐

6. When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ☐ No ☐ Yes
If "No," please go to Item 7. 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 check (✓) **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 check** (✓) **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 UNUSUAL 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 check (√)**]**

☐ No	☐ Yes	An operation or new illness	☐ No	☐ Yes	Change(s) of arthritis drugs or other drugs
☐ No	☐ Yes	A patient visit or stay in a hospital	☐ No	☐ Yes	Change(s) of address
☐ No	☐ Yes	A fall, broken bone, or other trauma	☐ No	☐ Yes	Change(s) of marital status
☐ No	☐ Yes	An important new symptom	☐ No	☐ Yes	Change job or work duties, quit work, retired
☐ No	☐ Yes	Side effect(s) of any 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:

SEX: ☐ Female, ☐ Male **ETHNIC GROUP:** ☐ Asian, ☐ Black, ☐ Hispanic, ☐ White, ☐ Other _____

Your Occupation _____

Work Status: ☐ Full-time, ☐ Part-time, ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐ Retired,
☐ Seeking work, ☐ Other _____

Please circle the number of years of school you have completed:
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

Please write your weight: _____ **lbs. height:** _____ **inches**

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

 Thank you for completing this questionnaire to help keep track of your medical care. **R791NP2**

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.
Date: _____ Signature _____