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
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 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
__Weight gain (>10 lbs)
__Weight loss (<10 lbs)
__Feeling sickly
__Headaches
__Unusual fatigue
__Swollen glands
__Loss of appetite
__Skin rash or hives
__Unusual bruising or bleeding
__Other skin problems
__Loss of hair
__Dry eyes
__Other eye problems
__Problems with hearing
__Ringing in the ears
__Stuffy nose
__Sores in the mouth
__Dry mouth
__Problems with smell or taste

__Lump in your throat
__Cough
__Shortness of breath
__Wheezing
__Pain in the chest
__Heart pounding (palpitations)
__Trouble swallowing
__Heartburn or stomach gas
__Stomach pain or cramps
__Nausea
__Vomiting
__Constipation
__Diarrhea
__Dark or bloody stools
__Problems with urination
__Gynecological (female) problems
__Dizziness
__Losing your balance
__Muscle pain, aches, or cramps
__Muscle weakness

__Paralysis of arms or legs
__Numbness or tingling of arms or legs
__Fainting spells
__Swelling of hands
__Swelling of ankles
__Swelling in other joints
__Joint pain
__Back pain
__Neck pain
__Use of drugs not sold in stores
__Smoking cigarettes
__More than 2 alcoholic drinks per day
__Depression - feeling blue
__Anxiety - feeling nervous
__Problems with thinking
__Problems with memory
__Problems with sleeping
__Sexual problems
__Burning in sex organs
__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																					FATIGUE IS A MAJOR 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

10. Over the last 6 months have you had: [Please check (√)**]**

☐No ☐Yes An operation or new illness
☐No ☐Yes A patient visit or stay in a hospital
☐No ☐Yes A fall, broken bone, or other trauma
☐No ☐Yes An important new symptom
☐No ☐Yes Side effect(s) of any drug
☐No ☐Yes Smoke cigarettes regularly
☐No ☐Yes Change(s) of arthritis drugs or other drugs
☐No ☐Yes Change(s) of address
☐No ☐Yes Change(s) of marital status
☐No ☐Yes Change job or work duties, quit work, retired
☐No ☐Yes Change of medical insurance, Medicare, etc.
☐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_____