Multi-Dimensional Health Assessment Questionnaire (R811-NP4)

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. 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

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

Name:______________________ **D.O.B**____________ **Date:**____________

Please fill out both sides of this form →

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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) ☐

Cat:

HS = >12

MS = 6.1-12

LS = 3.1-6

R = $\leq$3

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

			FOR OFFICE USE ONLY
___Fever	___Lump in your throat	___Paralysis of arms or legs	5. ROS: ☐
___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	

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

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 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:

____

____

11. Please list below any medications which you cannot take because you are allergic to them:

__________ __________ __________ __________

12. Please list below anything else (grass, molds, pollens, etc.) you might be allergic to:

__________ __________ __________ __________

Signature ______________________________

13. Please check (✓) either "No" or "Yes" to indicate whether or not you have any of the conditions below:

Have you ever had: **If you answer "Yes", please list AGE or YEAR when it began.**

Condition	No	Yes	AGE or YEAR
High Blood Pressure or Hypertension	___No	___Yes	_____ or _____
Heart attack	___No	___Yes	_____ or _____
Other heart disease	___No	___Yes	_____ or _____
Cancer	___No	___Yes	_____ or _____
Stroke	___No	___Yes	_____ or _____
Bronchitis or Emphysema	___No	___Yes	_____ or _____
Asthma	___No	___Yes	_____ or _____
Other Lung problem	___No	___Yes	_____ or _____
Anemia (Low Blood)	___No	___Yes	_____ or _____
Other hematologic problem	___No	___Yes	_____ or _____
Stomach ulcer	___No	___Yes	_____ or _____
Other gastrointestinal (GI) problem	___No	___Yes	_____ or _____
Thyroid problem	___No	___Yes	_____ or _____
Diabetes	___No	___Yes	_____ or _____
Kidney problem	___No	___Yes	_____ or _____
Other ____________________ (Please name)			_____ or _____

Condition	No	Yes	AGE or YEAR
Gynecological (Female)/ Prostate (Male) problem	___No	___Yes	_____ or _____
Severe allergies	___No	___Yes	_____ or _____
Rheumatoid arthritis	___No	___Yes	_____ or _____
Osteoarthritis	___No	___Yes	_____ or _____
Lupus	___No	___Yes	_____ or _____
Back or spine problems	___No	___Yes	_____ or _____
Fibromyalgia (Fibrositis)	___No	___Yes	_____ or _____
Osteoporosis	___No	___Yes	_____ or _____
Broken bones after age 50	___No	___Yes	_____ or _____
Dry mouth	___No	___Yes	_____ or _____
Dry eyes	___No	___Yes	_____ or _____
Cataracts	___No	___Yes	_____ or _____
Parkinson's disease	___No	___Yes	_____ or _____
Depression	___No	___Yes	_____ or _____
Mental illness	___No	___Yes	_____ or _____
Alcoholism	___No	___Yes	_____ or _____
Other ____________________ (Please name)			_____ or _____

14. Please list below all operations you have ever had. Please check (✓) here if none: _______.

	Operation	Year	Surgeon	Hospital, City, State
1.				
2.				
3.				
4.				

(You may continue below or on a separate page)

15. Please list below all major illnesses or hospital admissions (other than for operations).
Please check (✓) here if none: ______.

	Illness or Reason for hospitalization	Year	Hospital, City, State
1.			
2.			
3.			
4.			

(You may continue below or on a separate page)

16. The questions below concern your family medical history:

	If Living		If Deceased	
	Birth Year or Age	Any Major Medical Conditions	Year or Age at death	Cause(s) of death
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

17. Any blood relative (parent, child, brother, sister, aunt, uncle) with: If "Yes", give relationship.

	No	Yes	Relation(s)
Rheumatoid Arthritis	____	____	____________
Lupus or SLE	____	____	____________

18. Any illnesses which run in the family?______________________________

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19. Please write below all pills that you took over the last TWO WEEKS, with or without a prescription. Include aspirin, birth control pills, pain pills, alternative therapy, health supplements, pills sold in health food stores:

NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY	DOSE (if known)	How Many per day or week?	NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY	DOSE (if known)	How Many Per day or week?
1. ______	______	______	7. ______	______	______
2. ______	______	______	8. ______	______	______
3. ______	______	______	9. ______	______	______
4. ______	______	______	10. ______	______	______
5. ______	______	______	11. ______	______	______
6. ______	______	______	12. ______	______	______

20. What is your current occupation? (If you are not working now, what was your past occupation?)

____

21. At this time, are you?[Please check(✓)all that apply.]

__Working full time __Retired
__Working part time __Student
__Homemaker-full time __Disabled
__Seeking work __Other (describe)__________

22. How many other people live at home with you? ___
[Please check (✓) who lives with you.]
__Spouse/partner __Parents __Sons or daughters
__I live alone __Others (describe)______________

23. How many years of school have you completed?
Please circle the number of years of school:

1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

24. Please write your weight: ____lbs. height: ___in.

Your Name______________________________ **Today's Date**____________ **Time of Day**____ **AM/PM**
First Middle Last

Street Address________________________ **City**______________ **State**____ **Zip**__________

Telephone (___) ______________ **Social Security #**______________ **Date of Birth** ____________
Area Code Number For Identification Purposes Only

SEX: ☐ Female ☐ Male **ETHNIC GROUP:** ☐ Asian ☐ Hispanic ☐ Other ☐ Black ☐ White **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Please check if this questionnaire is completed ☐ **entirely by patient** OR ☐ **with help from (name)**______________

WE ASK YOU FOR CONSENT TO REVIEW YOUR RECORDS FOR MEDICAL RESEARCH AND TO CONTACT YOU IN THE FUTURE. YOUR CARE WILL NOT BE AFFECTED IF YOU ANSWER "NO."
I agree to allow information from my medical record to be reviewed for medical research, and for you to send me similar questionnaires in the future, which I am not required to answer. I understand that this information will remain confidential with my doctor and his or her research associates only. Please check **(✓)** in **one** box. Thank you!

☐ **YES** ☐ **NO** Signature______________________________ Date ______________

I understand and agree that my doctor may share this information with colleagues at other medical research centers, in order to learn more about best treatments for my condition. Please check **(✓)** in **one** box. Thank you!

☐ **YES** ☐ **NO** Signature______________________________ Date ______________

Please list the name, address, and telephone number of your primary care physician:
Name______________________________ Address______________________________
City, State ZIP ______________________________ Telephone ______________________________

Please list the name of your rheumatologist and insurance center:
Rheumatologist______________________________ Insurance______________________________

Please list the name, address, and telephone number of someone who lives at a different address from you, and who will be likely to know your whereabouts if we are unable to reach you:
Name______________________________ Address______________________________
City, State ZIP ______________________________ Telephone______________ Relationship __________

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.
Date: ______________________ Signature______________________________

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