Multi-Dimensional Health Assessment Questionnaire (M801.51 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. <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

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 ○ PAIN AS BAD AS IT COULD BE

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

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 ○ VERY POORLY

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

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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)

3.RADAI(0-48)

FAST3(0-3)

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

__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. # SX: ☐

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

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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:

_____ _____ _____ _____

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. AGE or YEAR	Have you ever had:			AGE or YEAR
High Blood Pressure or Hypertension	___No	___Yes	____ or ____	Gynecological (Female)/ Prostate (Male) problem	___No	___Yes	____ or ____
Heart attack	___No	___Yes	____ or ____	Severe allergies	___No	___Yes	____ or ____
Other heart disease	___No	___Yes	____ or ____	Rheumatoid arthritis	___No	___Yes	____ or ____
Cancer	___No	___Yes	____ or ____	Osteoarthritis	___No	___Yes	____ or ____
Stroke	___No	___Yes	____ or ____	Lupus	___No	___Yes	____ or ____
Bronchitis or Emphysema	___No	___Yes	____ or ____	Back or spine problems	___No	___Yes	____ or ____
Asthma	___No	___Yes	____ or ____	Fibromyalgia (Fibrositis)	___No	___Yes	____ or ____
Other Lung problem	___No	___Yes	____ or ____	Osteoporosis	___No	___Yes	____ or ____
Anemia (Low Blood)	___No	___Yes	____ or ____	Broken bones after age 50	___No	___Yes	____ or ____
Other hematologic problem	___No	___Yes	____ or ____	Dry mouth	___No	___Yes	____ or ____
Stomach ulcer	___No	___Yes	____ or ____	Dry eyes	___No	___Yes	____ or ____
Other gastrointestinal (GI) problem	___No	___Yes	____ or ____	Cataracts	___No	___Yes	____ or ____
				Parkinson's disease	___No	___Yes	____ or ____
Thyroid problem	___No	___Yes	____ or ____	Depression	___No	___Yes	____ or ____
Diabetes	___No	___Yes	____ or ____	Mental illness	___No	___Yes	____ or ____
Kidney problem	___No	___Yes	____ or ____	Alcoholism	___No	___Yes	____ or ____
Other _____ (Please name)			____ 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)		No	Yes	Relation(s)
Rheumatoid Arthritis				Lupus or SLE			

18. Any illnesses which run in the family? _____

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 by selected colleagues of my doctor, 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 and telephone number of your primary care physician:

Name_____ 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 _____

 Thank you for completing this questionnaire to help keep track of your medical care. R801.51 NP4R

FOR OFFICE USE ONLY: I have reviewed and recorded relevant questionnaire responses.

Date: _____ Signature_____