NAME DATE-OF-BIRTH DATE

Multi-Dimensional Health Assessment Questionnaire (R827-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	_____ 3.2
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
	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	

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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)

Category:
HS = >12
MS = 6.1-12
LS = 3.1-6
MDA = ≤3

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

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5. ROS: ☐

___ 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
___ Problem 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 blood 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

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 Better ☐ (1), Better ☐ (2), the Same ☐ (3), Worse ☐ (4), Much Worse ☐ (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 Medical emergency or stay overnight in hospital
☐ No ☐ Yes A fall, broken bone, or other accident or trauma
☐ No ☐ Yes An important new symptom or medical problem
☐ No ☐ Yes Side effect(s) of any medication or drug
☐ No ☐ Yes Smoke cigarettes regularly

☐ No ☐ Yes Change(s) of arthritis or other medication
☐ 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 _____ **Please circle the number of years of school you have completed:**

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

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. **R827NP2**

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

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