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. 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

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 3.2
l. Deal with feelings of anxiety or being nervous? 0 1.1 2 3.3
m. Deal with feelings of depression or feeling blue? 0 1.1 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 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

a. LEFT FINGERS 0 1 2 3  
b. LEFT WRIST 0 1 2 3  
c. LEFT ELBOW 0 1 2 3  
d. LEFT SHOULDER 0 1 2 3  
e. LEFT HIP 0 1 2 3  
f. LEFT KNEE 0 1 2 3  
g. LEFT ANKLE 0 1 2 3  
h. LEFT TOES 0 1 2 3  
q. NECK 0 1 2 3  
i. RIGHT FINGERS 0 1 2 3  
j. RIGHT WRIST 0 1 2 3  
k. RIGHT ELBOW 0 1 2 3  
l. RIGHT SHOULDER 0 1 2 3  
m. RIGHT HIP 0 1 2 3  
n. RIGHT KNEE 0 1 2 3  
o. RIGHT ANKLE 0 1 2 3  
p. RIGHT TOES 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 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
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
POORLY

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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
- Problem with hearing
- Ringing in the ears
- Stuffy nose
- Sores in the mouth
- Dry mouth
- Problems with smell or taste
- 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 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 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

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

Please write your weight: ______ lbs.  height: ______ inches

Your Name ___________________________ Date of Birth ___________ Today’s Date __________

Page 2 of 2   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: ___________________________