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. 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:

- Dress yourself, including tying shoelaces and doing buttons?
- Get in and out of bed?
- Lift a full cup or glass to your mouth?
- Walk outdoors on flat ground?
- Wash and dry your entire body?
- Bend down to pick up clothing from the floor?
- Turn regular faucets on and off?
- Get in and out of a car, bus, train, or airplane?
- Walk two miles or three kilometers, if you wish?
- Participate in recreational activities and sports as you would like, if you wish?
- Get a good night’s sleep?
- Deal with feelings of anxiety or being nervous?
- Deal with feelings of depression or feeling blue?

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 IT COULD BE PAIN AS BAD AS

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:

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

Please turn to the other side
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
- 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

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 A MAJOR PROBLEM
   □ 10 □ 9 □ 8 □ 7 □ 6 □ 5 □ 4 □ 3 □ 2 □ 1 □ No Problem

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 __________________________ 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. R791NP2

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