Multi-Dimesional Health Assessment Questionnaire

Please select the response which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	○	○	○	○
Wash and dry your entire body?	○	○	○	○
ARISING				
Are you able to:				
Bend down to pick up clothing from the floor?	○	○	○	○
Get in and out of bed?	○	○	○	○
ABOUT THE DAY				
Are you able to:				
Turn regular faucets on and off?	○	○	○	○
Lift a full cup or glass to your mouth?	○	○	○	○
Get in and out of a car, bus, train, or airplane?	○	○	○	○
WALKING				
Are you able to:				
Walk outdoors on flat ground?	○	○	○	○
Walk two miles or three kilometers, if you wish?	○	○	○	○
Participate in recreational activities, and sports as you would like, if you wish?	○	○	○	○

How much pain have you had because of your condition OVER THE PAST WEEK?

0 - NO PAIN ..... 10 - PAIN AS BAD AS IT COULD BE

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

0 - VERY WELL ..... 10 - VERY POORLY

NAME_____

Please click in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

Review Questionnaire

Start

	None	Mild	Moderate	Severe
a. LEFT FINGERS	○	○	○	○
b. LEFT WRIST	○	○	○	○
c. LEFT ELBOW	○	○	○	○
d. LEFT SHOULDER	○	○	○	○
e. LEFT HIP	○	○	○	○
f. LEFT KNEE	○	○	○	○
g. LEFT ANKLE	○	○	○	○
h. LEFT TOES	○	○	○	○
q. NECK	○	○	○	○

	None	Mild	Moderate	Severe
i. RIGHT FINGERS	○	○	○	○
j. RIGHT WRIST	○	○	○	○
k. RIGHT ELBOW	○	○	○	○
l. RIGHT SHOULDER	○	○	○	○
m. RIGHT HIP	○	○	○	○
n. RIGHT KNEE	○	○	○	○
o. RIGHT ANKLE	○	○	○	○
p. RIGHT TOES	○	○	○	○
r. BACK	○	○	○	○

When you awakened in the morning OVER THE LAST WEEK, did you feel stiff? ○ No ○ Yes If Yes:

Please indicate the number of hours and/or minutes until you are as limber as you will be for the day. Hours ____

Minutes ____

How do you feel TODAY compared to ONE WEEK AGO?

Much Better (1) ○ Better (2) ○ the Same (3) ○ Worse (4) ○ Much Worse (5) ○ than one week ago

Please click YES if you have experienced any of the following over the last month, otherwise click NO:

YES	NO		YES	NO		YES	NO	
○	○	Fever	○	○	Coughing up blood	○	○	Painful urination
○	○	Weight gain >10lbs	○	○	Wheezing	○	○	Loss of hair
○	○	Weight loss > 10lbs	○	○	Painful respiration	○	○	Sleep disturbances
○	○	Loss of appetite	○	○	Pain in the chest	○	○	Seizures
○	○	Headaches	○	○	Heart pounding (palpitations)	○	○	Dizziness
○	○	Dry eyes	○	○	Fingers or toes turning colors	○	○	Losing your balance
○	○	Double vision	○	○	Stomach pain	○	○	Depression
○	○	Eye redness	○	○	Stomach gas	○	○	Nail changes
○	○	Eye pain	○	○	Diarrhea	○	○	Rash resulting from sun exposure
○	○	Vision loss	○	○	Constipation	○	○	Skin rash
○	○	Ringing in the ears	○	○	Bloody stools	○	○	Hives
○	○	Stuffy nose	○	○	Dark stools	○	○	Muscle weakness
○	○	Sore throat	○	○	Heartburn	○	○	Muscle pain, aches
○	○	Trouble swallowing	○	○	Nausea	○	○	Swollen glands
○	○	Sores in the mouth	○	○	Vomiting	○	○	Abnormal bleeding
○	○	Dry mouth	○	○	Blood in urine	○	○	Easy bruising
○	○	Cough	○	○	Urinary incontinence	○	○	Environmental allergies
○	○	Shortness of breath				○	○	Food Allergies
○	○	Joint Swelling				○	○	Asthma
○	○	Jaw pain with chewing						

How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least one-half hour (30 minutes)? Please click only one.

- ○ 3 or more times a week
- ○ 1-2 times per week
- ○ 1-2 times per month
- ○ Do not exercise regularly
- ○ Cannot exercise due to disability/handicap

How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

0 - FATIGUE IS NO PROBLEM [ ] 10 - FATIGUE IS A MAJOR PROBLEM ○ ○

Since your last visit, have you?

Yes	No		Yes	No	
○	○	Had any illnesses?	○	○	Had any change in your social history?
○	○	Had any x-ray, lab or other procedures?	○	○	Had any new allergies or reactions to medications?
○	○	Had any change in your family medical history?	○	○	Started, changed or stopped any medications?

Tobacco Use

○ Current ○ Former ○ Never ○ Unknown

Alcohol Use

○ Yes ○ Former ○ No