RHEUMATOLOGY ASSOCIATES

RAPID Health Assessment

Multi-Dimensional Health Assessment Questionnaire

Name _____ Date _____

1. Daily activities, pain & overall health

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

Select one response per activity.

	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

Rating (0-10): _____

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

Rating (0-10): _____

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2. Joint pain, stiffness & change

Please select the amount of pain you are having today in each of the joint areas listed below. Select one response per area.

JOINT AREA	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	☐	☐	☐	☐
i. RIGHT FINGERS	☐	☐	☐	☐
j. RIGHT WRIST	☐	☐	☐	☐
k. RIGHT ELBOW	☐	☐	☐	☐
l. RIGHT SHOULDER	☐	☐	☐	☐
m. RIGHT HIP	☐	☐	☐	☐
n. RIGHT KNEE	☐	☐	☐	☐
o. RIGHT ANKLE	☐	☐	☐	☐
p. RIGHT TOES	☐	☐	☐	☐
q. NECK	☐	☐	☐	☐
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)

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3. Symptoms over the last month

Please select YES if you have experienced any of the following over the last month; otherwise select NO. Select one response for every symptom.

SYMPTOM	YES	NO
Fever	☐	☐
Weight gain >10 lbs	☐	☐
Weight loss >10 lbs	☐	☐
Loss of appetite	☐	☐
Headaches	☐	☐
Dry eyes	☐	☐
Double vision	☐	☐
Eye redness	☐	☐
Eye pain	☐	☐
Vision loss	☐	☐
Ringing in the ears	☐	☐
Stuffy nose	☐	☐
Sore throat	☐	☐
Trouble swallowing	☐	☐
Sores in the mouth	☐	☐
Dry mouth	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Joint Swelling	☐	☐
Jaw pain with chewing	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Painful respiration	☐	☐
Pain in the chest	☐	☐
Heart pounding (palpitations)	☐	☐
Fingers or toes turning colors	☐	☐
Stomach pain	☐	☐
Stomach gas	☐	☐

SYMPTOM	YES	NO
Diarrhea	☐	☐
Constipation	☐	☐
Bloody stools	☐	☐
Dark stools	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Blood in urine	☐	☐
Urinary incontinence	☐	☐
Painful urination	☐	☐
Loss of hair	☐	☐
Sleep disturbances	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Losing your balance	☐	☐
Depression	☐	☐
Nail changes	☐	☐
Rash resulting from sun exposure	☐	☐
Skin rash	☐	☐
Hives	☐	☐
Muscle weakness	☐	☐
Muscle pain, aches	☐	☐
Swollen glands	☐	☐
Abnormal bleeding	☐	☐
Easy bruising	☐	☐
Environmental allergies	☐	☐
Food Allergies	☐	☐
Asthma	☐	☐

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4. Exercise, fatigue & health updates

EXERCISE

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

Please select 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

FATIGUE

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

Rating (0-10): _____

SINCE YOUR LAST VISIT, HAVE YOU?	YES	NO
Had any illnesses?	☐	☐
Had any x-ray, lab or other procedures?	☐	☐
Had any change in your family medical history?	☐	☐
Had any change in your social history?	☐	☐
Had any new allergies or reactions to medications?	☐	☐
Started, changed or stopped any medications?	☐	☐

Tobacco Use ☐ Current ☐ Former ☐ Never ☐ Unknown

Alcohol Use ☐ Yes ☐ Former ☐ No