# Multi-Dimensional Health Assessment Questionnaire (R780-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.**

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**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 | 3.3 |
| 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 | o 0 | o 1 | o 2 | o 3 | i.RIGHT FINGERS | o 0 | o 1 | o 2 | o 3 |
| b.LEFT WRIST | o 0 | o 1 | o 2 | o 3 | j.RIGHT WRIST | o 0 | o 1 | o 2 | o 3 |
| c.LEFT ELBOW | o 0 | o 1 | o 2 | o 3 | k.RIGHT ELBOW | o 0 | o 1 | o 2 | o 3 |
| d.LEFT SHOULDER | o 0 | o 1 | o 2 | o 3 | l.RIGHT SHOULDER | o 0 | o 1 | o 2 | o 3 |
| e.LEFT HIP | o 0 | o 1 | o 2 | o 3 | m.RIGHT HIP | o 0 | o 1 | o 2 | o 3 |
| f.LEFT KNEE | o 0 | o 1 | o 2 | o 3 | n.RIGHT KNEE | o 0 | o 1 | o 2 | o 3 |
| g.LEFT ANKLE | o 0 | o 1 | o 2 | o 3 | o.RIGHT ANKLE | o 0 | o 1 | o 2 | o 3 |
| h.LEFT TOES | o 0 | o 1 | o 2 | o 3 | p.RIGHT TOES | o 0 | o 1 | o 2 | o 3 |
| q.NECK | o 0 | o 1 | o 2 | o 3 | r.BACK | o 0 | o 1 | o 2 | o 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

**Please turn to the other side**

For Office Use Only: RAPID 3 RAPID 3 (0-10)

NR: 1=0.3, 2=0.7, 3=1.0 LS: 4=1.3, 5=1.7, 6=2.0
MS: 7=2.3, 8=2.7, 9=3.0, 10=3.3, 11=3.7, 12=4.0
HS: 13=4.3, 14=4.7, 15=5.0, 16=5.3, 17=5.7,18=6.0, 19=6.3, 20=6.7, 21=7.0, 22=7.3, 23=7.7, 24=8.0, 25=8.3, 26=8.7, 27=9.0, 28=9.3, 29=9.7, 30=10.0

RAPID 4 RAPID 4 (0-10)

NR: 1=0.3, 2=0.5, 3=0.8, 4=1.0 LS: 5=1.3, 6=1.5, 7=1.8, 8=2.0
MS: 9=2.3, 10=2.5, 11=2.8, 12=3.0, 13=3.3, 14=3.5, 15=3.8, 16=4.0
HS: 17=4.3, 18=4.5, 19=4.8, 20=5.0, 21=5.3, 22=5.5, 23=5.8, 24=6.0, 25=6.3, 26=6.5, 27=6.8, 28=7.0, 29=7.3, 30=7.5, 31=7.8, 32=8.0, 33=8.3, 34=8.5, 35=8.7, 36=9.0, 37=9.3, 38=9.5, 39=9.8, 40=10.0

RAPID 5 (0-10)

NR: 1=0.2, 2=0.4, 3=0.6, 4=0.8 5=1.0 LS: 6=1.2, 7=1.4, 8=1.6, 9=1.8, 10=2.0,
MS:11=2.2, 12=2.4, 13=2.6, 14=2.8, 15=3.0, 16=3.2, 17=3.4, 18=3.6, 19=3.8, 20=4.0
HS: 21=4.2, 22=4.4, 23=4.6, 24=4.8, 25=5.0, 26=5.2, 27=5.4, 28=5.6, 29=5.8, 30=6.0, 31=6.2, 32=6.4, 33=6.6, 34=6.8, 35=7.0, 36=7.2, 37=7.4, 38=7.6, 39=7.8, 40=8.0, 41=8.2, 42=8.4, 43=8.6, 44=8.8, 45=9.0, 46=9.2, 47=9.4, 48=9.6, 49=9.8, 50=10.0

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1.a-j FN (0-10)

1=0.3 2=0.7 3=1.0 4=1.3 5=1.7 6=2.0 7=2.3 8=2.7 9=3.0 10=3.3 11=3.7 12=4.0 13=4.3 14=4.7 15=5.0 16=5.3 17=5.7 18=6.0 19=6.3 20=6.7 21=7.0 22=7.3 23=7.7 24=8.0 25=8.3 26=8.7 27=9.0 28=9.3 29=9.7 30=10

2.PN (0-10)

4.PTGL (0-10)

RAPID 3 (0-30)

3.a-pPTJT(0-10)

1=0.2 2=0.4 3=0.6 4=0.8 5=1.0 6=1.3 7=1.5 8=1.7 9=1.9 10=2.1 11=2.3 12=2.5 13=2.7 14=2.9 15=3.1 16=3.3 17=3.5 18=3.8 19=4.0 20=4.2 21=4.4 22=4.6 23=4.8 24=5.0 25=5.2 26=5.4 27=5.6 28=5.8 29=6.0 30=6.3 31=6.4 32=6.7 33=6.9 34=7.1 35=7.3 36=7.5 37=7.7 38=7.9 39=8.1 40=8.3 41=8.5 42=8.8 43=9.0 44=9.2 45=9.4 46=9.6 47=9.8 48=10

RAPID 4 (0-40)

MDGLOBAL(0-10))

RAPID 5 (0-50)

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

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| | | |
|---|---|---|
| ___Fever | ___Lump in your throat | ___Paralysis of arms or legs |
| ___Weight gain (>10 lbs) | ___Cough | ___Numbness or tingling of arms or legs |
| ___Weight loss (<10 lbs) | ___Shortness of breath | ___Fainting spells |
| ___Feeling sickly | ___Wheezing | ___Swelling of hands |
| ___Headaches | ___Pain in the chest | ___Swelling of ankles |
| ___Unusual fatigue | ___Heart pounding (palpitations) | ___Swelling in other joints |
| ___Swollen glands | ___Trouble swallowing | ___Joint pain |
| ___Loss of appetite | ___Heartburn or stomach gas | ___Back pain |
| ___Skin rash or hives | ___Stomach pain or cramps | ___Neck pain |
| ___Unusual bruising or bleeding | ___Nausea | ___Use of drugs not sold in stores |
| ___Other skin problems | ___Vomiting | ___Smoking cigarettes |
| ___Loss of hair | ___Constipation | ___More than 2 alcoholic drinks per day |
| ___Dry eyes | ___Diarrhea | ___Depression - feeling blue |
| ___Other eye problems | ___Dark or bloody stools | ___Anxiety - feeling nervous |
| ___Problems with hearing | ___Problems with urination | ___Problems with thinking |
| ___Ringing in the ears | ___Gynecological (female) problems | ___Problems with memory |
| ___Stuffy nose | ___Dizziness | ___Problems with sleeping |
| ___Sores in the mouth | ___Losing your balance | ___Sexual problems |
| ___Dry mouth | ___Muscle pain, aches, or cramps | ___Burning in sex organs |
| ___Problems with smell or taste | ___Muscle weakness | ___Problems with social activities |

5.ROS ☐
6. AM ☐
7.CHG ☐
8. EX ☐
9. FT ☐
10.HX ☐

**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.**
**M**uch **B**etter o (1), **B**etter o (2), the **S**ame o (3), **W**orse o (4), **M**uch **W**orse o (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 O O O O O O O O O O O O O O O O O O O O O FATIGUE IS A
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 | ☐No ☐Yes | Change(s) of arthritis drugs or other drugs |
| ☐No ☐Yes | Inpatient hospitalization | ☐No ☐Yes | Change(s) of address |
| ☐No ☐Yes | A new illness, accident or trauma | ☐No ☐Yes | Change(s) of marital status |
| ☐No ☐Yes | An important new symptom | ☐No ☐Yes | Change job or work duties, quit work, retired |
| ☐No ☐Yes | Side effect(s) of any drug | ☐No ☐Yes | Change of medical insurance, Medicare, etc. |
| ☐No ☐Yes | Smoke cigarettes regularly | ☐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** _____
**Work Status:** ☐ Full-time, ☐ Part-time, ☐ Disabled
☐ Homemaker, ☐ Self-Employed, ☐Retired,
☐ Seeking work, ☐ Other_____

**Please circle the number of years of school you have completed:**
1 2 3 4 5 6 7 8 9 10
11 12 13 14 15 16 17 18 19 20

**Please record 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.** **R780NP2**

**FOR OFFICE USE ONLY:** I have reviewed [check(✓)]: ___FN, ___ PN, ____GL, ___RAPID, ___RADAI, ____ROS, ____HX
Name: _____ Signature_____