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DATE

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.

Till lease cheek (V) the Old best answer for your abindes at this time.						FOR OFFICE USE ONLY	
OVER THE LAST WEEK, were you able to:	Without ANY <u>Difficulty</u>	With SOME Difficulty	MU	ith J CH i <u>culty</u>		ABLE Do	1.a-j FN (0-10):
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	<u> </u>	· •		3	
b. Get in and out of bed?	0	1		2		3	1 = 0.3
c. Lift a full cup or glass to your mouth?d. Walk outdoors on flat ground?	0	1		2 2		3 3	4 = 1.3 19 = 6.3 5 = 1.7 20 = 6.7 6 = 2.0 21 = 7.0
e. Wash and dry your entire body?	0	1		2		3	7 = 2.3 22 = 7.3 8 = 2.7 23 = 7.7 9 = 3.0 24 = 8.0
f. Bend down to pick up clothing from the floor? g. Turn regular faucets on and off?	0	l 1		2 2		3 3	10 = 3.3
h. Get in and out of a car, bus, train, or airplane?	0	1		2		3	12 = 4.0 27 = 9.0 13 = 4.3 28 = 9.3 14 = 4.7 29 = 9.7
i. Walk two miles or three kilometers, if you wish?j. Participate in recreational activities and sports	0	٠		2 2		3 3	15 = 5.0 30 = 10
as you would like, if you wish? k. Get a good night's sleep?	0	ـــــــــــــــــــــــــــــــــــــ	.1	∠ 2.2		3 3.3	2.PN (0-10):
l. Deal with feelings of anxiety or being nervous?	0	1	.1	2.2		3.3	2.174 (0-10).
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 you	our condition	n OVER 1	THE PAS	ST WE	EK?		4.PTGL (0-10):
Please indicate below how severe your pair	n nas been:	000	000	ר האם	N AS B	۸ ا	
PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5					COULD		DADID O (O OO)
							RAPID 3 (0-30)
3. Please place a check $(\sqrt{\ })$ in the appropriate are having today in each of the joint areas			amoun	t of pa	in yo	u	
None Mild Moderate Severe	nsteu below		ione Mi	ld Mc	oderate	Severe	Category:
a. LEFT FINGERS 0 0 1 0 2 13	i. RIGHT FIN] 1	□ 2	□ 3	HS = >12 MS = 6.1-12
b. LEFT WRIST	j. RIGHT WE] 1	□ 2 □ 2	□ 3	LS = 3.1-6 MDA = ≤3
<u>c. LEFT ELBOW</u> □ 0 □ 1 □ 2 □ 3 <u>d. LEFT SHOULDER</u> □ 0 □ 1 □ 2 □ 3	k. RIGHT EL] 1] 1	□ 2 □ 2	□ 3 □ 3	
e. LEFT HIP	m. RIGHT H] 1	□ 2	□ 3	
<u>f. LEFT KNEE</u>	n. RIGHT KN] 1] 1	□ 2		
h. LEFT TOES	o. RIGHT AND RIGHT TO] 1	□ 2 □ 2	□ 3 □ 3	
<u>q. NECK</u> □ 0 □ 1 □ 2 □ 3	<u>r. BACK</u>		□ 0	J 1	□ 2	□ 3	
4. Considering all the ways in which illness a	nd health co	nditions	mav a	ffect v	ou at	this	
time, please indicate below how you are doing:							
VERY 0 0 0 0 0 0 0 0 0 0	0000	00	000) VER	RΥ		

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

5. Please check ($$) if you ha	we experienced any of the follow	ring <u>over the last month:</u>	
—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 Please check (√) here if vo	Lump in your throatCoughShortness of breathWheezingPain in the chestHeart pounding (palpitations)Trouble swallowingHeartburn or stomach gasStomach pain or crampsNauseaVomitingConstipationDiarrheaDark or bloody stoolsProblems with urinationGynecological (female) problemsDizzinessLosing your balanceMuscle pain, aches, or crampsMuscle weakness pu have had none of the above or	Problems with sleeping Sexual problems Burning in sex organs Problems with social activities	5. ROS:
 If "No," please go to Item 7. until you are as limber as yo 7. How do you feel TODAY of Much Better □ (1), Better □ (1) 8. How often do you exercis one-half hour (30 minutes) □ 3 or more times a week (3) 	If "Yes," please indicate the nur u will be for the day. ompared to ONE WEEK AGO? Please (2), the Same □ (3), Worse □ (4) e aerobically (sweating, increased I ? Please check (✓) only one. □ 1-2 times per month (1)	K, did you feel stiff? ☐ No ☐ Yes mber of minutes, or hours ease check (✓) only one. e), Much Worse ☐ (5) than one week a heart rate, shortness of breath) for at le	ago east
O Herr words of a madelant be			173
FATIGUE IS OOOO	O O O O O O O 5.5 6.0 6		K.? UE IS A R PROBLEM
□No □Yes An operation or new □No □Yes Medical emergency of □No □Yes A fall, broken bone, □No □Yes An important new sy □No □Yes Side effect(s) of any □No □Yes Smoke cigarettes reg	or stay overnight in hospital or other accident or trauma or medical problem or medication or drug	☐Yes Change(s) of arthritis or other ☐Yes Change(s) of address ☐Yes Change(s) of marital status ☐Yes Change job or work duties, qui ☐Yes Change of medical insurance, I ☐Yes Change of primary care or other health matter that affects you:	t work, retired Medicare, etc.
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