Paducah Rheumatology

Multi-Dimensional Health Assessment Questionnaire (R808-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.

Without With With With To Do									FOR OFFICE			
a. Dress yourself, including tying shoelaces and doing buttons? Do 1 2 3 Do Get in and out of bed? C. Lift a full cup or glass to your mouth? Do 1 2 3 Do 1 3 2 Do 1 4 2 3 Do 1 4 2 3 Do 1 4 2 3 Do 1 5 2 Do 1 5 2 3 Do 1 5 2 Do	OVER THE LAST W	VEEK, v	were y	ou able t	o:	ANY	SOME		MUCH	1 <u>T</u>		1.a-j FN (0-10):
Please indicate below how severe your pain has been: NO ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	doing buttons? b. Get in and out of c. Lift a full cup or gd. Walk outdoors on e. Wash and dry you f. Bend down to pic g. Turn regular fauch. Get in and out of i. Walk two miles o j. Participate in recras you would like k. Get a good night'l. Deal with feelings	bed? glass to flat group k up clo ets on a car, l r three reationa fi you s sleep s of anx	your round? e bodyothing and of bus, trakilomeal actives wish?	mouth? ? from the f? ain, or ai eters, if y ities and being n	floor? rplane? ou wish? sportservous?	000000000		1		2 2 2 2 2 2 2.2	3 3 3 3 3 3 3 3 3 3 3 3 3	2=0.7 17=5.7 3=1.0 18=6.0 4=1.3 19=6.3 5=1.7 20=6.7 6=2.0 21=7.0 7=2.3 22=7.3 8=2.7 23=7.7 9=3.0 24=8.0 10=3.3 25=8.3 11=3.7 26=8.7 12=4.0 27=9.0 13=4.3 28=9.3 14=4.7 29=9.7 15=5.0 30=10
are having today in each of the joint areas listed below: None None Mild Moderate Severe None Mild Moderate Severe Cat: a. LEFT FINGERS 0 0 0 1 0 2 0 3 i. RIGHT FINGERS 0 0 0 1 0 2 0 3 i. RIGHT WRIST 0 0 0 1 0 2 0 3 i. RIGHT WRIST 0 0 0 1 0 2 0 3 i. RIGHT WRIST 0 0 0 1 0 2 0 3 i. RIGHT WRIST 0 0 0 1 0 2 0 3 i. RIGHT ELBOW 0 0 0 1 0 2 0 3 i. RIGHT ELBOW 0 0 0 0 1 0 2 0 3 i. RIGHT SHOULDER 0 0 0 1 0 2 0 3 i. RIGHT SHOULDER 0 0 0 1 0 2 0 3 i. RIGHT SHOULDER 0 0 0 1 0 2 0 3 i. RIGHT HIP 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Please indicate	below	how	severe	your pai	in has been:	000	0 0) O F	PAIN AS E		4.PTGL (0-10): RAPID 3 (0-30)
a. LEFT FINGERS \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT FINGERS \square 0 \square 1 \square 2 \square 3 $ $ b. LEFT WRIST \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT WRIST \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT WRIST \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT WRIST \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT ELBOW \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT SHOULDER \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT SHOULDER \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT SHOULDER \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT HIP \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT HIP \square 0 \square 1 \square 2 \square 3 $ $ i. RIGHT KNEE \square 1 \square 2 \square 3 $ $ i. RIGHT KNEE \square 1 \square 1 \square 2 \square 3 \square 3 \square 3 \square 3 \square 3 \square 3 \square	are having toda	ay in e	ach of	f the joi	nt areas		v:			-		
h. LEFT TOES □ 0 □ 1 □ 2 □ 3 p. RIGHT TOES □ 0 □ 1 □ 2 □ 3 q. NECK □ 0 □ 1 □ 2 □ 3 r. BACK □ 0 □ 1 □ 2 □ 3 4. Considering all the ways in which illness and health conditions may affect you at this	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	□ 0 □ 0 □ 0 □ 0 □ 0 □ 0 □ 0		☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2 ☐ 2	□ 3 □ 3 □ 3 □ 3 □ 3 □ 3 □ 3	j. RIGHT WI k. RIGHT EL I. RIGHT SH m. RIGHT H n. RIGHT KI o. RIGHT AI p. RIGHT TO r. BACK	NGERS RIST BOW OULDER IIP NEE NKLE DES	0 0 0 0 0 0 0	01 01 01 01 01 01	□ 2 □ 2 □ 2 □ 2 □ 2 □ 2 □ 2	3 3 3 3 3 3 3 3 3	HS = >12 MS = 6.1-12 LS = 3.1-6

VERY O O O O O O O O O O O O O O O O O O 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 POORLY

time, please indicate below how you are doing:

5. Please check ($$) if you ha	ve experienced any of the following	ng over the last month:	
FeverWeight gain (>10 lbs)Weight loss (>10 lbs)Feeling sicklyHeadachesUnusual fatigueSwollen glandsLoss of appetiteSkin rash or hivesUnusual bruising or bleedingOther skin problemsLoss of hairDry eyesOther eye problemsProblems with hearingRinging in the earsStuffy noseSores in the mouthDry mouthProblems with smell or taste	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	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	FOR OFFICIUSE ONLY 5. ROS:
	$\underline{}$ Muscle weakness $\underline{}$		
of your condition.7. List any medications we p	rues you would like to discuss with provide which need refilled. Please 30 or 90 supplies are desired.	your provider today, apart from roo	itine follow
8. Please note any hospitaliz since your last visit.	ations, ER visits, surgeries, new o	changing medical conditions or me	dications
Your Name	Date of Birtl	1 Today's Date	