Multi-Dimensional Health Assessment Questionnaire (MDHAQ-RP2)

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer, even if you do not think it is related to you at this time. <u>There are no right or wrong answers.</u> Please answer each question exactly as you think or feel. Thank you.

1. Please check (✓) the ONE best answer for your abilities at this time:

AT THIS MOMENT, are 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?	_____0	_____1	_____2	_____3
j. Participate in sports and games as you would like?	_____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? Place a mark on the line below to indicate how severe your pain has been:

NO PAIN |————————————————————————| PAIN AS BAD AS IT COULD BE

3. Which of the following best describes you TODAY? Please check (✓) only one:

___1: I can do everything I want to do.
___2: I can do most of the things I want to do, but have some limitations.
___3: I can do some, but not all, of the things I want to do, and I have many limitations.
___4: I can do hardly any of the things I want to do.

4. When you get up in the morning, do you feel stiff? ___Yes ___No
If you answer "No", please go to item 6.

5. If you answer "Yes," please write the number of minutes: ____, OR number of hours: ____until you are as limber as you will be for the day?

6. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK? Place a mark on the line below:

FATIGUE IS NO PROBLEM |————————————————————————| FATIGUE IS A MAJOR PROBLEM

7. How do you feel TODAY compared to TWO WEEKS AGO? Please check (✓) only one:

___1: Much better today than two weeks ago.
___2: Better today than two weeks ago.
___3: The same today as two weeks ago.
___4: Worse today than two weeks ago.
___5: Much worse today than two weeks ago.

8. How SATISFIED are you with your ability to do your usual activities? Please check (✓) only one:

___1: Very Satisfied
___2: Somewhat Satisfied
___3: Somewhat Dissatisfied
___4: Very Dissatisfied

9. Considering all the ways in which illness and health conditions may affect you at this time, please make a mark below to show how you are doing?

VERY WELL |————————————————————————| VERY POORLY

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FN

1=0.33	16=5.33
2=0.67	17=5.67
3=1.00	18=8.00
4=1.33	19=8.33
5=1.67	20=6.67
6=2.00	21=7.00
7=2.33	22=7.33
8=2.67	23=7.67
9=3.00	24=8.00
10=3.33	25=8.33
11=3.67	26=8.67
12=4.00	27=9.00
13=4.33	28=9.33
14=4.67	29=9.67
15=5.00	30=10.00

PS

PN

FT

GL

10. Please check (✓) if you have experienced any of the following over the last month:

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SY

__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

__Lump in your throat
__Cough
__Shortness of breath
__Wheezing
__Pain in the chest
__Heart pounding (palpitations)
__Trouble swallowing
__Heartburn or stomach gas
__Stomach pain or cramps
__Nausea
__Vomiting
__Constipation
__Diarrhea
__Dark or bloody stools
__Problems with urination
__Gynecological (female) problems
__Dizziness
__Losing your balance
__Muscle pain, aches, or cramps
__Muscle 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

11. The statements below concern your personal beliefs. Please circle the number beside each statement that best describes how you feel about the statement. There are no right or wrong answers.

		STRONGLY DISAGREE	DISAGREE	DO NOT AGREE OR DISAGREE	AGREE	STRONGLY AGREE
a.	My condition is controlling my life.	1	2	3	4	5
b.	I would feel helpless if I couldn't rely on other people for help with my condition.	1	2	3	4	5
c.	I am concerned that medicines cannot help me.	1	2	3	4	5
d.	The side effects of medicines are often worse that the disease.	1	2	3	4	5
e.	I often do not take my medicines as directed.	1	2	3	4	5
f.	No matter what I do, or how hard I try, I just can't seem to get relief from my symptoms.	1	2	3	4	5
g.	I am not coping effectively with my condition.	1	2	3	4	5
h.	It seems as though fate and other factors beyond my control affect my condition.	1	2	3	4	5

12. Please write below all the drugs or medicines you have taken over the last two weeks. (Include aspirin, birth control pills, and any drug or medicine with or without prescription):

	NAME OF DRUG OR MEDICINE	DOSE (if known)	How many per day or week?		NAME OF DRUG OR MEDICINE	DOSE (if known)	How many per day or week?
1.	_____	_____	_____	7.	_____	_____	_____
2.	_____	_____	_____	8.	_____	_____	_____
3.	_____	_____	_____	9.	_____	_____	_____
4.	_____	_____	_____	10.	_____	_____	_____
5.	_____	_____	_____	11.	_____	_____	_____
6.	_____	_____	_____	12.	_____	_____	_____

(Please list any others on a separate page)

Any of these drugs cause you side effects? ❑ No, ❑ Yes. If "Yes", please write the drug(s) and the side effect(s) below.

_____

Your Name _____ Today's Date_____ Time of day_____ AM PM

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE TO MONITOR YOUR MEDICAL SITUATION.