Avera Medical Group Rheumatology
6100 S. Louise Ave.
Suite 1130
Sioux Falls, SD 57108
605-504-1600

Name: _____

Date of Birth: _____

Today's Date: _____

Multi-Dimensional Health Assessment Questionnaire

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.

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

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. 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

4. 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
LEFT FINGERS	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT FINGERS	❑ 0	❑ 1	❑ 2	❑ 3
LEFT WRIST	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT WRIST	❑ 0	❑ 1	❑ 2	❑ 3
LEFT ELBOW	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT ELBOW	❑ 0	❑ 1	❑ 2	❑ 3
LEFT SHOULDER	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT SHOULDER	❑ 0	❑ 1	❑ 2	❑ 3
LEFT HIP	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT HIP	❑ 0	❑ 1	❑ 2	❑ 3
LEFT KNEE	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT KNEE	❑ 0	❑ 1	❑ 2	❑ 3
LEFT ANKLE	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT ANKLE	❑ 0	❑ 1	❑ 2	❑ 3
LEFT TOES	❑ 0	❑ 1	❑ 2	❑ 3	RIGHT TOES	❑ 0	❑ 1	❑ 2	❑ 3
NECK	❑ 0	❑ 1	❑ 2	❑ 3	BACK	❑ 0	❑ 1	❑ 2	❑ 3

New patients, please stop here. Returning patients, please turn to the other side and complete the back side.

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1. a-j **FN** (0-10): ☐

1=0.3	16=5.3
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

2. PN (0-10): ☐

3. PTGL (0-10): ☐

RAPID 3 (0-30) ☐

Disease Activity/Severity

High	>12
Medum	6.1-12
Low	3.1-6
Remission	< 3

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5. ROS: ☐

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

___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 alcohol 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

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.
Much **B**etter ❑ **B**etter ❑ the **S**ame ❑ **W**orse ❑ **M**uch **W**orse ❑ 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/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ Do not exercise regularly
❑ Cannot exercise due to disability/ handicap

9. How much of a problem has UNUSUAL fatigue or tiredness been for you OVER THE PAST WEEK?

FATIGUE IS	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	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 (√)]

❑ Yes ❑ No An operation or new illness
❑ Yes ❑ No A patient visit or stay in a hospital
❑ Yes ❑ No A fall, broken bone, or other trauma
❑ Yes ❑ No An important new symptom
❑ Yes ❑ No Side effect(s) of any drug
❑ Yes ❑ No Smoke cigarettes regularly

❑ Yes ❑ No Change(s) of arthritis drugs or other drugs
❑ Yes ❑ No Change(s) of address
❑ Yes ❑ No Change(s) of marital status
❑ Yes ❑ No Change job or work duties, quit work, retired
❑ Yes ❑ No Change of medical insurance, Medicare, etc.
❑ Yes ❑ No Change of primary care or other doctor

Please explain any "Yes" answer below, or indicate any other health matter that affects you:

_____

_____

Your Occupation _____

Work Status: ❑ Full-time ❑ Part-time ❑ Disabled ❑ Homemaker ❑ Self-Employed ❑ Retired ❑ Seeking work
❑ Other_____

Page 2 of 2 Thank you for completing this questionnaire to help keep track of your medical care.

FOR OFFICEUSE ONLY: I have reviewed the questionnaire responses.
Date:_____ Signature:_____

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