MULTI-DIMENSIONAL HEALTH ASSESSMENT QUESTIONNAIRE (MDHAQ)

Answer questions 1, 2, and 6 of the MDHAQ (pronounced em-dee-HACK) to calculate your RAPID3 score and rheumatoid arthritis (RA) disease activity

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

MDHAQ EnV8 **R865**

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

OVER THE PAST WEEK, were you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
Participate in sports and games as you would like?	☐ 0	☐ 1	☐ 2	☐ 3
Get a good night's sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3

FN (1) ☐

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

PN (2) ☐

PTGL (6) ☐

RAPID3 ☐

(0-30)

Category
HS= >12
MS=6.1-12
LS= 3.1-6
R= ≤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 ○○○○○○○○○○○○○○○○○○○○○ **PAIN AS BAD AS IT COULD BE**
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

3. When you awakened in the morning **OVER THE PAST WEEK**, did you feel stiff? ☐ **No** ☐ **Yes**
If "**Yes**," please indicate the number of minutes_____, or hours_____ until you are as limber as you will be for the day

4. How much of a problem has **UNUSUAL** fatigue or tiredness been for you **OVER THE PAST WEEK?** Please indicate below:

FATIGUE IS NO PROBLEM ○○○○○○○○○○○○○○○○○○○○○ **FATIGUE IS A MAJOR PROBLEM**
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

5. How do you feel **TODAY** compared to **ONE WEEK AGO**? Please check (✓) only one.
(1) **M**uch **B**etter ☐, (2) **B**etter ☐, (3) the **S**ame ☐, (4) **W**orse ☐, (5) **M**uch **W**orse ☐

6. 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 ○○○○○○○○○○○○○○○○○○○○○ **VERY POORLY**
0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

7. 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** ☐ **1-2 times per week** ☐ **1-2 times per month** ☐ **Do not exercise regularly**
☐ **Cannot exercise due to disability/ handicap**

8. Over the last 6 months, have you had: [please check (✓) **NO** or **YES –** please do not leave blank]

An operation or new illness	☐ **No**	☐ **Yes**	Change(s) of arthritis or other medication	☐ **No**	☐ **Yes**
A patient visit or stay at a hospital	☐ **No**	☐ **Yes**	Change(s) of address	☐ **No**	☐ **Yes**
An important new symptom	☐ **No**	☐ **Yes**	Change(s) of marital status	☐ **No**	☐ **Yes**
Side effects of any drugs	☐ **No**	☐ **Yes**	Change job or work duties, quit work, retired	☐ **No**	☐ **Yes**
Smoke cigarettes regularly	☐ **No**	☐ **Yes**	Change of medical insurance, Medicare, etc.	☐ **No**	☐ **Yes**
A fall, accident or other trauma	☐ **No**	☐ **Yes**	Change of primary care or other doctor	☐ **No**	☐ **Yes**

Please explain any "Yes" answers:_____

Please turn over

9. Please check (√) if you have experienced any of the following <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

__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

Please check (√) here if you have had none of the above over the last month: _____.

10. Please place a check (✓) in the appropriate box to indicate how much pain you are having today in each joint area:

	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

11. Please list all the medications you have taken over the last 2 weeks (if more than 6, please list on a separate page).

NAME OF MEDICINE	**DOSE**	**NAME OF MEDICINE**	**DOSE**
1. _____	_____	**4.** _____	_____
2. _____	_____	**5.** _____	_____
3. _____	_____	**6.** _____	_____

Allergies to medications:_____

12. What is the name of the condition for which you are here today? _____

Year _____ or your age_____ when you first had symptoms of this condition.

Year _____ or your age_____ when you were diagnosed with this condition.

13. How many years of school have you completed? Please circle the number of years of school.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

14. At this time, are you? Please check (✓) all that apply:

☐Working full-time, ☐Working part-time, ☐Student, ☐Homemaker—full-time, ☐Unemployed,
☐Retired, ☐Disabled, ☐Other (describe):_____ Your occupation is/was _____

Your: **SEX:** ☐ Female ☐ Male **ETHNIC GROUP:** ☐ Asian ☐ Hispanic ☐ Other ☐ Black ☐ White **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

FOR DOCTOR USE ONLY: I have reviewed the questionnaire responses. Date: _____Signature_____

VERY WELL ○○○○○○○○○○○○○○○○○○○○ VERY POORLY

0 0.5 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10

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