



# 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



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TRA656613-01

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

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



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:



5. How do you feel **TODAY** compared to **ONE WEEK AGO?** Please check (✓) only one.  
 (1) **Much Better** , (2) **Better** , (3) **the Same** , (4) **Worse** , (5) **Much Worse**

6. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:



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           | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change(s) of arthritis or other medication    | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |
| A patient visit or stay at a hospital | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change(s) of address                          | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |
| An important new symptom              | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change(s) of marital status                   | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |
| Side effects of any drugs             | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change job or work duties, quit work, retired | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |
| Smoke cigarettes regularly            | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change of medical insurance, Medicare, etc.   | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |
| A fall, accident or other trauma      | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> | Change of primary care or other doctor        | <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Yes</b> |

Please explain any "Yes" answers: \_\_\_\_\_

**Please turn over**

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fever                        | <input type="checkbox"/> Lump in your throat             | <input type="checkbox"/> Paralysis of arms or legs            |
| <input type="checkbox"/> Weight gain (>10 lbs)        | <input type="checkbox"/> Cough                           | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (>10 lbs)        | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Fainting spells                      |
| <input type="checkbox"/> Feeling sickly               | <input type="checkbox"/> Wheezing                        | <input type="checkbox"/> Swelling of hands                    |
| <input type="checkbox"/> Headaches                    | <input type="checkbox"/> Pain in the chest               | <input type="checkbox"/> Swelling of ankles                   |
| <input type="checkbox"/> Unusual fatigue              | <input type="checkbox"/> Heart pounding (palpitations)   | <input type="checkbox"/> Swelling in other joints             |
| <input type="checkbox"/> Swollen glands               | <input type="checkbox"/> Trouble swallowing              | <input type="checkbox"/> Joint pain                           |
| <input type="checkbox"/> Loss of appetite             | <input type="checkbox"/> Heartburn or stomach gas        | <input type="checkbox"/> Back pain                            |
| <input type="checkbox"/> Skin rash or hives           | <input type="checkbox"/> Stomach pain or cramps          | <input type="checkbox"/> Neck pain                            |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea                          | <input type="checkbox"/> Use of drugs not sold in stores      |
| <input type="checkbox"/> Other skin problems          | <input type="checkbox"/> Vomiting                        | <input type="checkbox"/> Smoking cigarettes                   |
| <input type="checkbox"/> Loss of hair                 | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes                     | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Depression - feeling blue            |
| <input type="checkbox"/> Other eye problems           | <input type="checkbox"/> Dark or bloody stools           | <input type="checkbox"/> Anxiety - feeling nervous            |
| <input type="checkbox"/> Problems with hearing        | <input type="checkbox"/> Problems with urination         | <input type="checkbox"/> Problems with thinking               |
| <input type="checkbox"/> Ringing in the ears          | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory                 |
| <input type="checkbox"/> Stuffy nose                  | <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Problems with sleeping               |
| <input type="checkbox"/> Sores in the mouth           | <input type="checkbox"/> Losing your balance             | <input type="checkbox"/> Sexual problems                      |
| <input type="checkbox"/> Dry mouth                    | <input type="checkbox"/> Muscle pain, aches, or cramps   | <input type="checkbox"/> Burning in sex organs                |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness                 | <input type="checkbox"/> 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:**

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>		<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
LEFT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
NECK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	BACK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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).**

<u>NAME OF MEDICINE</u>	<u>DOSE</u>	<u>NAME OF MEDICINE</u>	<u>DOSE</u>
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     Black     White     Other    **MARITAL STATUS:**  Single     Married     Divorced     Widowed     Separated

**FOR DOCTOR USE ONLY:** I have reviewed the questionnaire responses. Date: \_\_\_\_\_ Signature \_\_\_\_\_

VERY WELL



VERY POORLY