# MULTIDIMENSIONAL 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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Pfizer
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Medical Affairs

**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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