WILMINGTON HEALTH

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 not 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
k. Get a good night's sleep?	0	1	2	3
l. Deal with feelings of anxiety or being nervous?	0	1	2	3
m. Deal with feelings of depression or feeling blue?	0	1	2	3

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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 WORST POSSIBLE PAIN

3. 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
a. LEFT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3	j. RIGHT FINGERS	☐ 0	☐ 1	☐ 2	☐ 3
b. LEFT WRIST	☐ 0	☐ 1	☐ 2	☐ 3	k. RIGHT WRIST	☐ 0	☐ 1	☐ 2	☐ 3
c. LEFT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3	l. RIGHT ELBOW	☐ 0	☐ 1	☐ 2	☐ 3
d. LEFT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3	m. RIGHT SHOULDER	☐ 0	☐ 1	☐ 2	☐ 3
e. LEFT HIP	☐ 0	☐ 1	☐ 2	☐ 3	n. RIGHT HIP	☐ 0	☐ 1	☐ 2	☐ 3
f. LEFT KNEE	☐ 0	☐ 1	☐ 2	☐ 3	o. RIGHT KNEE	☐ 0	☐ 1	☐ 2	☐ 3
g. LEFT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3	p. RIGHT ANKLE	☐ 0	☐ 1	☐ 2	☐ 3
h. LEFT TOES	☐ 0	☐ 1	☐ 2	☐ 3	q. RIGHT TOES	☐ 0	☐ 1	☐ 2	☐ 3
i. NECK	☐ 0	☐ 1	☐ 2	☐ 3	r. BACK	☐ 0	☐ 1	☐ 2	☐ 3

4. 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

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

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

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

6. When you awakened in the morning OVER THE LAST WEEK, di 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 Better –(1), Better – (2), the Same -(3), Worse – (4), Much Worse – (5) 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 a week (3) ☐ 1-2 times per month (1) ☐ Cannot exercise due to disability/handicap (9)
☐ 1-2 times per week (2) ☐ Do not exercise regularly (0)

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

FATIGUE IS 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 FATIGUE IS A MAJOR PROBLEM

10. Over the last 6 months have you had: [Please check (✓)]

☐ No	☐ Yes	An operation or new illness	☐ No	☐ Yes	Change(s) of arthritis or other medication
☐ No	☐ Yes	Medical emergency or stay overnight in hospital	☐ No	☐ Yes	Change(s) of address
☐ No	☐ Yes	A fall, broken bone, or other accident or trauma	☐ No	☐ Yes	Change(s) of marital status
☐ No	☐ Yes	An important new symptom or medical problem	☐ No	☐ Yes	Change job or work duties, quit work, retired
☐ No	☐ Yes	Side effect(s) of any medication or drug	☐ No	☐ Yes	Change of medical insurance, Medicare, etc.
☐ No	☐ Yes	Smoke cigarettes regularly	☐ No	☐ Yes	Change of primary care or other doctor

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

_____

_____

Your name: _____ Date of Birth: _____ Today's Date: _____

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

FOR OFFICE USE ONLY: I have reviewed the questionnaire responses.

Date: _____ Signature: _____