**Arthritis & Osteoporosis Treatment Center, P.A.**
**Douglas Roane, M.D.**

Multi-Dimensional Health Assessment Questionnaire (R791-Np2) RPQ

**ACCT #** _____
**Patient Name:** _____ **DOB:**_____ **Appt. Date:** _____
**Patients e-mail address:** _____
**Primary Care Provider:** _____ **Last visit:** _____

FOR OFFICE USE ONLY

2. a-j FN (o-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

3. PN (0-10):

5. PTGL (0-10):

RAPID 3 (0-30)

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

**No Fatigue** **Fatigue is a**

0.0 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**

2. 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 feeling of anxiety or being nervous? | 0 | 1 | 2 | 3 |
| m. Deal with feelings of depression of feeling blue? | 0 | 1 | 2 | 3 |

**3. 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**

0.0 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 **IT COULD BE**

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

**5. Considering all the ways in which illness and health may affect you at this time, Please indicate below how you are doing:**

**VERY WELL** **VERY POORLY**

0.0 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

**Physician signature:**_____ **Date:**_____

PATIENT NAME:_____ DOB:_____ DATE:_____

**REVIEW OF SYSTEMS:** **(*NOTE: ALL UNMARKED ITEMS INDICATE A NEGATIVE RESPONSE)**

**Please check each symptom as it pertains to you *since last visit*.**

**CONSTITUTIONAL:**
__ Recent weight loss/amount
__ Fatigue
__ Fatigue
_ Chills_
__ Fever

**NERVOUS SYSTEM:**
__ Headaches
__ Dizziness
__ Numbness
__ Tremors
__ Seizure disorder

__ Others
_____

**ALLERGY/IMMUNOLOGY:**
__ Hay fever
__ Drug allergy
_____
__ Other
_____

**EARS/NOSE/THROAT**
__ Sudden loss of hearing
__ Ear infection
__ Sinus problems
__Dry mouth
__Sore Throat_
__Other _____

**EYES:**
__Blurred vision
__Double vision
__Dry eyes
__Eye pain
__Other _____

**ENDOCRINE:**
__ Excessive thirst
__ Too hot/cold
__Tired/sluggish
__Other

**HEMATOLOGIC/LYMPH:**
__ Anemia
__ Blood clotting problem
__ Swollen glands
__Other _____

**CARDIOVASCULAR:**
__ Chest pain
__ Swelling legs or feet
__Varicose veins
__High blood pressure
__Heart murmur
__Other _____

**RESPIRATORY:**
__ Shortness of breath
__ Frequent cough
__Night sweats
__ Snoring

**GASTROINTESTINAL:**
__ Nausea/vomiting
__ Stomach pain
__ Heartburn
__ Persistent diarrhea

**GENITOURINARY:**
__ Pain or burning urination
__ Urinary frequency
__Urinary retention
__ Discharge from penis or vagina
__ Genital sores/ulcers
_Other
_____

**RHEUMATOLOGIC**
__Sun sensitive rash
__Red eyes/scleritis/ conjunctivitis
__Difficulty swallowing
__Frequent sores in mouth
__ Color changes in hands or feet with cold

**OB/GYN (if applies)**
__Last menstrual period _____
__ # pregnancies _____
__# live births _____
__ # children _____

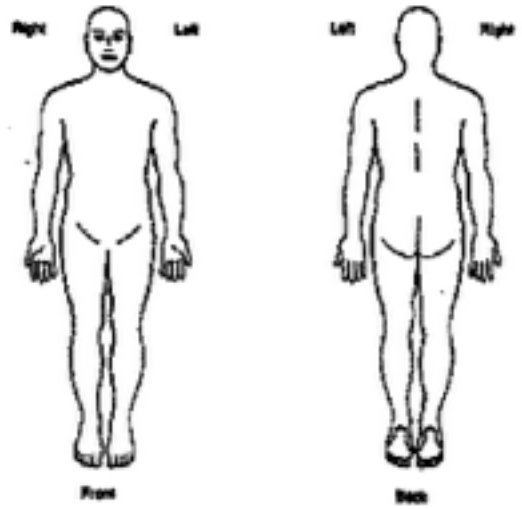
-

**SKIN:**
__ Skin rash
__ Boils
__ Persistent itching
__ Recent hair loss
__Other
_____

**PSYCHIATRIC:**
__Depression
__Anxiety
__Mood swings

**MUSCLES/JOINTS**
__ Morning stiffness
Lasting how long?
__ Minutes
__ Hours
__ Joint pain
__ Balance Problems
__ Muscle weakness
__ Joint swelling

ON THE DIAGRAM BELOW, PLEASE MARK WHERE YOU HAVE PAIN:

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Reviewed by _____ Date: _____

Revised 3/22/17