Follow Up Visit Questionaire
(revised form MDHAQ)
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Print

RAPID5 Multi Dimensional Health Assessment Questionaire(MDHAQ)

YOUR NAME: **Date of Birth:** **Today's Date:**

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, 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

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 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 **PAIN AS BAD AS IT COULD BE**

3. Please place a check () in the appropriate spot to indicate the amount of the pain you are having today in each of the joint areas listed below:

	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

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 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 **VERY POORLY**

DO NOT WRITE BELOW THIS - FOR DOCTORS USE ONLY - MD Global

VERY WELL 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 **VERY POORLY**

FN 0-10

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

PN 0-10

PTGL 0-10

RAPID3 0-30

JT CT 0-10

1-0.2	25-5.2
2-0.4	26-5.4
3-0.6	27-5.6
4-0.8	28-5.8
5-1.0	29-6.0
6-1.3	30-6.3
7-1.5	31-6.4
8-1.7	32-6.7
9-1.9	33-6.9
10-2.1	34-7.1
11-2.3	35-7.3
12-2.5	36-7.5
13-2.7	37-7.7
14-2.9	38-7.9
15-3.1	39-8.1
16-3.3	40-8.3
17-3.5	41-8.5
18-3.8	42-8.8
19-4.0	43-9.0
20-4.2	44-9.2
21-4.4	45-9.4
22-4.6	46-9.6
23-4.8	47-9.8
24-5.0	48-10

RAPID4 0-40

MDGL: 0-10

RAPID5 0-50

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

Fever	Lump in your thorat	Paralysis of arms or legs
Weight Gain (>10 lbs)	Cough	Fainting spells
Weight Loss (<10 lbs)	Shortness of breath	Numbness or tingling of arms or legs
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 appetite	Heartburn or stomach gas	Back pain
Skin rash or hives	Stomach pain or cramps	Neck pain
Unusual bruising or bleeding	Nausea	Use of drugs not sold in stores
Othe skin problems	Vomiting	Smoking cigarettes
Loss of hair	Constipation	More than two alchohlic drinks per day
Dry Eyes	Diarrhea	Depression - feeling blue
Other Eye problems	Dark or bloody stools	Anxiety - feeling nervous
Problem with hearing	Problem with urination	Problem with thinking
Ringing in the ears	Gynecological(Female) problems	Problem with memory
Stuffy nose	Dizziness	Problem with sleeping
Sores in the mouth	Losing your balance	Sexual problems
Dry mouth	Muscle pain, aches, or cramps	Burning in sex organs
Problem with smell or taste	Muscle weakness	Problem with social activities

6.When you awakened in the morning OVER THE LAST WEEK, did 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.

(1). **M**uch Better ,(2). **B**etter ,(3). the **S**ame ,(4). **W**orse (5). **M**uch **W**orse than one week ago.

8.How often do you exercise aerobically (sweating, increase heart rate, shortness of breath) **for atleast one-half hour(30 minutes)? Please check(✓) only one.** 3 or more times a week (3) 1-2 times per month (1)
1-2 times per week (2) Do not exercise regularly (0) Cannot exercise due to disability/ handicap (9)

9. How much of a problem has UNUSAUL fatigue or tiredeness 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	No	Yes	Change(s) of arthritis drugs or other drugs
No	Yes	Inpatient hospitalization	No	Yes	Change(s) of address
No	Yes	a new illness, accident or truma	No	Yes	Change(s) of marital status
No	Yes	An important new symptom	No	Yes	Change job or work duties, quit work, retired
No	Yes	Side effect(s) of any 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:

_____

_____

SEX: Female, Male **ETHNIC GROUP:** Asian, Black, Hispanic, White, Other _____

Your Occupation _____ **Circle the number of years of school you have completed:**

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

Work Status: Full time Part time Disabled
Homemaker Self-Employed Retired
Seeking Work Other _____ **Record Your weight:** _____ **lbs. height:** _____ **inches**

Your Name _____ Date of Birth _____ Todat's Date _____

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

Medication List For: **Date**

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

New Allergies:

Have you seen any other physicians since your last visit? Please explain.

Have you changed any medications since last visit? Added New Changed doses, Stopped. Please explain.