RHEUMATOLOGY HEALTH ASSESSMENT QUESTIONNAIRE

Name : ____

DOB : ____ /____ / ____ Date : ____ /____ / ____

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 no right or wrong answers. Please answer exactly as you think or feel.

1.) Please place a check mark (√) in the appropriate spot for the ONE best answer for your abilities at this time:

	OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty (0)	With **SOME** Difficulty (1)	With **MUCH** Difficulty (2)	**UNABLE** To Do (3)
a.	Dress yourself, including tying shoelaces and doing buttons?				
b.	Get in and out of bed?				
c.	Lift a full cup or glass to your mouth?				
d.	Walk outdoors on flat ground?				
e.	Wash and dry your entire body?				
f.	Bend down to pick up clothing from the floor?				
g.	Turn regular faucets on and off?				
h.	Get in and out of a car, bus, train or airplane?				
i.	Walk two miles or three kilometers, if you wish?				
j.	Participate in recreational activities and sports as you would like?				

2.) Please indicate how severe your pain has been because of your condition OVER THE PAST WEEK?

NO PAIN	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	SEVERE 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	

When did the pain begin?	
What makes you feel better? Worse?	
Do you have pain at rest? ☐ Yes ☐ No	Do you have pain with activity? ☐ Yes ☐ No

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

		None (0)	**Mild (1)**	**Moderate (2)**	**Severe (3)**			**None (0)**	**Mild (1)**	**Moderate (2)**	**Severe (3)**
a.	Left Fingers					i.	Right Fingers				
b.	Left Wrist					j.	Right Wrist				
c.	Left Elbow					k.	Right Elbow				
d.	Left Shoulder					l.	Right Shoulder				
e.	Left Hip					m.	Right Hip				
f.	Left Knee					n.	Right Knee				
g.	Left Ankle					o.	Right Ankle				
h.	Left Toes					p.	Right Toes				
q.	Neck					r.	Back				

Name: ______________________________________

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	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	VERY POORLY
	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	

5.) Please check mark (√) if you have experienced any of the following <u>over the last month</u>:

☐ Fever	☐ Trouble swallowing	☐ Diarrhea	☐ Skin rash
☐ Headache	☐ Pain in chest	☐ Dark or bloody stools	☐ Loss of hair
☐ Dry eyes	☐ Shortness of breath	☐ Problems with urination	☐ Depression feeling blue
☐ Sores in mouth	☐ Cough	☐ Unusual bruising or bleeding	☐ Anxiety-feeling nervous
☐ Dry mouth	☐ Stomach pain or cramps	☐ Numbness or tingling of arms/legs	☐ Problems with sleeping
☐ Problem with smell or taste	☐ Constipation	☐ Muscle weakness	☐ Problems with memory
		☐ Swelling of joints	

Please check (√) here if you had none of the above over the last month __________.